



**REDACTED REPORT**



DEPARTMENT OF VETERANS AFFAIRS  
Veterans Health Administration  
Washington DC 20420  
APR 30 2014

The Honorable Carolyn N. Lerner  
Special Counsel  
U.S. Office of Special Counsel  
1730 M Street, NW, Suite 300  
Washington, DC 20036

In Reply Refer To:

RE: OSC File Nos. DI-12-3816 and DI-13-1713

Dear Ms. Lerner:

Please find enclosed a second supplementary report on the status of the Department of Veterans Affairs (VA) implementation of the follow-up action plan for Case Nos. DI-12-3816 and DI-13-1713.

The original site visits to the G.V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi (hereafter, the Medical Center), took place in April and May 2013. The two investigative reports were submitted to your office in July 2013, and together they contained a total of 23 recommendations for the Medical Center, all which were endorsed by the Secretary.

In your conditional closure letter to the President and Congress dated September 17, 2013, you recommended VA take further action to ensure patients received appropriate care, and requested an update on actions taken to correct identified deficiencies. Your staff reiterated the request for specified updates by email dated October 23, 2013. The first interim supplemental report was provided to your office on November 12, 2013.

Responsibility for monitoring the Medical Center's implementation of the Department's action plan was assigned to the Office of the Medical Inspector (OMI). OMI made a site visit to the Medical Center on October 22-23, 2013, to evaluate the facility's progress in carrying out the action plan; OMI, along with the Deputy Under Secretary for Health for Operations and Management, continue to monitor the progress and sustainability of the action plan.

Thank you for the extensions granted for submission of this supplemental information and the opportunity to respond.

Sincerely,

A handwritten signature in black ink that reads "RL Jesse".

Robert L. Jesse, MD, PhD  
Principal Deputy Under Secretary for Health

Enclosure

**Office of the Medical Inspector  
Supplemental Report  
To the  
Office of Special Counsel  
G.V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi  
OSC File Nos. DI-12-3816 and DI-13-1713  
April 11, 2014**

OMI TRIM # 2014-D-390

## **Background**

At the direction of the Secretary, the Under Secretary for Health (USH) requested the Office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM) send a team of subject matter experts to investigate two separate referrals (DI-12-3816 and DI-13-1713) that had been submitted to the Secretary by the Office of Special Counsel (OSC) pursuant to 5 U.S.C. 1213(c). Both referrals concerned the G.V. (Sonny) Montgomery Veterans Affairs (VA) Medical Center in Jackson, Mississippi (hereafter, the Medical Center). In referring these matters, OSC had concluded a substantial likelihood exists that the whistleblowers' respective disclosures evidenced: (1) a violation of law, rule, or regulation; or (2) gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety. The investigative team of subject matter experts conducted site visits at the Medical Center on April 15–19, 2013, and May 7–8, 2013, that resulted in a total of 23 recommendations, all endorsed by the USH. As required by 5 U.S.C. 1213(d), the Department submitted its two investigative reports to OSC in July of 2013.

In OSC's conditional closure letter of September 17, 2013, to the White House and Congress, OSC requested VA provide an update on the activities taken to correct identified deficiencies. In response, the USH requested the Office of the Medical Inspector (OMI) to monitor the Medical Center's implementation of the Department's action plan (designed to correct identified deficiencies and address the reports' respective recommendations). The first update was provided to OSC on November 12, 2013; this constitutes the second. OMI and the DUSHOM continue to monitor the progress and sustainability of the action plan.

**Recommendation 1:** The Medical Center leadership must immediately correct the erroneous declaration that all nurse practitioners (NP) will practice as licensed independent practitioners (LIP).

**Resolution:** The Medical Center identified and obtained licensure requirements for all of its NPs. Each NP has been provided with a written letter informing him or her of the declaration of LIP or non-LIP status based on his or her state of licensure. NPs licensed in a state that does not recognize them as an LIP will perform duties under a scope of practice as outlined in their state license. The Medical Center will continually update and maintain an in-depth spreadsheet to track NP-specific information including

state of licensure, individual DEA certificate, certifications, LIP or non-LIP status, and physician collaborator as well as scope of practice information for non-LIPs.

**This action has been completed.**

**Recommendation 2:** Medical Staff Bylaws must be amended to indicate that NPs are considered LIPs only when their state licensure permits.

**Resolution:** The Medical Center drafted proposed changes to the Medical Center Bylaws. The proposed changes were presented to the Executive Board of the Governing Body for approval prior to presentation to the medical staff. The medical staff approved the changes to the Bylaws on October 30, 2013, and the Bylaws were approved by the Executive Board of Governing Body on October 31.

**This action has been completed.**

**Recommendation 3:** Medical Center leadership must immediately implement scopes of practice versus clinical privileges for NPs who are not permitted to practice as LIPs.

**Resolution:** The Medical Center identified the licensure states of all NPs. Those NPs licensed in states, such as Mississippi, where they are not permitted to practice as LIPs, have been issued scopes of practice. The Chief Nurse Executive has reviewed and approved all scopes of practice. Each scope of practice will be specific to the NP's certification and designated area of assignment, including acute care, adult care, family care, women's health, or surgical care. Several NPs have licensure in more than one state and have declared which license under which they are operating to ensure transparency with the requirement for scopes of practice if not operating under an NP license that allows for LIP status.

**This action has been completed.**

**Recommendation 4:** Medical Center leadership must immediately ensure that all NPs who require collaborative agreements in fact have them, and that they are approved by the NP's respective state licensing board.

**Resolution:** All NPs who are required by their licenses to work under a scope of practice have a collaborative agreement with a physician at the Medical Center. The Arkansas State Board of Nursing has agreed to allow the establishment of a collaborative agreement with a physician at the Medical Center who is not licensed in the state of Arkansas in lieu of their restriction for same-state licensure. The Medical Center maintains copies of all NP collaborative agreements. Upon renewal of their state license, the collaborating physician's information is entered into the NP's application for renewal. VA is not required to forward collaborative agreements to the state for approval.

**This action has been completed.**

**Recommendation 5:** Medical Center leadership should ensure the equitable distribution of collaborative agreements among physicians, and a reasonable limitation placed on the number of collaborative agreements for any one physician. If a state's Nursing Practice Act establishes a limitation on the number of collaborative agreements that a collaborating supervising physician may have with an NP at any one time, then the Medical Center needs to comply with such requirements.

**Resolution:** The Medical Center has complied with the individual state requirements for collaborative agreement ratios. The Medical Center currently employs NPs licensed in the states of Arkansas, Iowa, and Mississippi; none of these states have set maximum NP-to-physician ratio guidelines. The current maximum ratio of assigned collaborative NPs-to-physicians at the Medical Center is 4:1.

**This action has been completed.**

**Recommendation 6:** The Medical Center leadership should eliminate use of locum tenens physicians in Primary Care to the extent possible.

**Resolution:** As patient care access needs dictate, the Medical Center will limit the use of locum tenens physicians when possible. At present, there are no locums tenens physicians assigned to Primary Care.

**This action has been completed.**

**Recommendation 7:** Locum tenens physicians should not be physician collaborators because of their short tenure.

**Resolution:** At present, there are no locums tenens physicians assigned to Primary Care. The Medical Center has made a commitment to avoid, if at all possible, using locum tenens as collaborative physicians if any are hired in the future.

**This action has been completed.**

**Recommendation 8:** The Medical Center leadership must immediately implement a process to ensure that appropriate monitoring of NP practice by physician collaborators occurs and is documented in accordance with state licensure requirements.

**Resolution:** The Medical Center provided physician collaborators with the appropriate monitoring guidelines required by the state in which each assigned NP is licensed. VHA Handbook 5005/27 Part II Appendix G6 (PII-G6-10 through PII-G6-11) defines policy on collaborative relationships for Nurse II and Nurse III grades. The Medical Center's clinical service chiefs monitor physician collaborator requirements, and report compliance to leadership during the Quarterly Service Performance Dashboard Report. The current Dashboard compliance is 100 percent.

**This action has been completed.**

**Recommendation 9:** Medical Center leadership must continue to aggressively work to hire permanent full time physicians for Primary Care, to obtain an NP-to-physician ratio of 1:1. Once an adequate number of physicians are hired, the Medical Center will ensure that NP panel sizes are reduced to meet VHA guidelines.

**Resolution:** The Medical Center has hired additional full-time physicians. As the total physician panel size capacity increases, NP panel sizes will decrease and come in line with established patient-aligned care team (PACT) model recommendations. The current staffing in Primary Care is 9 physicians and 14 NPs. The facility continues to recruit for Primary Care Physicians through the Office of Workforce Management.

**This action has been completed.**

**Recommendation 10:** Medical Center leadership should consult the Office of Workforce Management and Consulting in VA Central Office (VACO) to ensure they are utilizing all available resources to recruit primary care physicians.

**Resolution:** The Medical Center uses the VISN 16 physician recruiter along with advertisement on the VA Careers Web site, in several professional journals, and at universities and medical schools. The physician recruiter attends career fairs and places advertisements nationally, to include Puerto Rico. There is currently a comprehensive recruitment action plan with Workforce Management as well.

**This action has been completed.**

**Recommendation 11:** Medical Center leadership should eliminate the use of ghost clinics. All clinics must have an assigned provider.

**Resolution:** The Medical Center has reviewed clinic names and provider profiles. All providers have been assigned to appropriate clinics. All clinics identified as no longer valid or required have been deleted and any assigned patients transferred to newly-hired health care providers.

**This action has been completed.**

**Recommendation 12:** Medical Center leadership should eliminate the use of overbooked and double-booked appointments to the extent possible. The Medical Center needs to implement the principles of open access scheduling, which means patients receive care when and where they want or need, including on the same day if requested.

**Status:** As the Medical Center recruits new physicians and establishes teams under the PACT model it anticipates that the need for overbooked appointments will decline. The Medical Center reviewed appointment grids for all providers, and on May 1, 2013, began to transition to open access scheduling based on the needs of the Veteran. Letters were mailed out to patients informing them of the scheduling changes.

The facility continues to move forward with implementing the principles of Open Access scheduling and is on target for completion by July 31, 2014.

**This action is ongoing.**

**Recommendation 13:** The Medical Center must convert 6-part credentialing and privileging (C&P) folders to the electronic VetPro system, as required by VHA leadership.

**Resolution:** All physicians and NPs are credentialed in VetPro. Leadership detailed a staff member into C&P from Primary Care to assist with document reconciliation and scanning of appropriate documentation into VetPro. Scanning was completed on October 15, 2013. OMI reviewed all primary care NP C&P folders in VetPro while on site on October 22, 2013, and found no deficiencies.

**This action has been completed.**

**Recommendation 14:** VISN 16 leadership should arrange for an external clinical quality review of all Primary Care at the Medical Center, particularly in light of the evidence that electronic View Alerts are often not being reviewed by physicians in a timely fashion and NPs were practicing outside the scope of their licensure. The Medical Center should conduct a clinical care review of a representative sample of the patient care records for all 42 NPs, as well as all physicians, who worked in Primary Care from January 1, 2010, to present. The VISN should work with Medical Center leadership to determine the sample size needed to ensure that the quality of care delivered by all of these providers was appropriate. If any clinical care issues are identified, the Medical Center should consider expanding the sample. Specific cases involving unresolved questions as to quality of care should be referred to OMI for further investigation.

**Status:** The VISN and Medical Center established that 30 patient care records would be reviewed, along with ongoing professional practice evaluation (OPPE) data, for each physician and NP to ensure quality care was delivered. The VISN identified clinical reviewers and the VISN 16 Deputy Chief Medical Officer, in conjunction with OMI, created a review tool to be used for the Quality Review. The VISN reviewed 67 providers, of whom 42 were NPs and 25 were MDs. A 38 USC §5705 protected peer review totaling 2,010 cases was completed by the VISN. No patients had an adverse event. Six of the 67 providers reviewed met the threshold for further review. Three of the six are no longer employed by VA. The three remaining providers still employed by VA will undergo a focused professional practice evaluation of additional cases.

**This action is ongoing.**

**Recommendation 15:** The VISN 16 leadership should actively assist the Medical Center to implement these recommendations (and any others it deems necessary to ensure quality care is consistently rendered and available to PCU patients) through an

approved action plan; and be responsible for submitting the action plan to the Under Secretary for Health along with periodic status reports (through to completion of all items).

**Resolution:** The VISN assigned a point of contact, the VISN 16 Accreditation Specialist, to assist in writing the action plan to address the recommendations, as well as ensuring actions are tracked until completed and closed out. The VISN and Medical Center have had two scheduled progress update meetings with OMI, and a face-to-face meeting, which included additional interviews with Medical Center staff, occurred October 22-23, 2013.

**This action has been completed.**

**Recommendation 16:** VHA should consider issuing an Information Letter (IL) to reinforce across the system the need for compliance with both NP state licensure requirements and with national policies on NP credentialing, privileging, and scopes of practice. Such guidance should identify Regional Counsels as an important resource for the facilities as they review program compliance requirements.

**Status:** The Office of Nursing Service's Advanced Practice Nursing Advisory Group (APNAG) created a guidance document on state licensure requirements and national policies on credentialing, privileging, and scopes of practice for NPs. The initial guidance document was created in December 2013. The APNAG is currently revising the guidance document in order to make it an official VHA publication.

**This action is ongoing.**

**Recommendation 17:** To determine whether Medicare home health certification forms are/were being appropriately completed by the PCU providers, VHA should task the appropriate VHA offices, e.g., the VHA Office of Compliance and Business Integrity and the Office of Patient Care Services, Home Health Program, to work together to conduct a random check of Medical Center PCU patient charts to determine if any Medicare forms are present, and if so, whether they were completed appropriately. Such findings need to be reported to the USH, who will then need to consider if any follow-up action is necessary. Additionally, Medical Center leadership should consider development a training and educational module for completion of these forms to ensure Primary Care and other staff are aware of Medicare compliance requirements.

**Resolution:** OMI interviewed physicians and NPs during the site visit and the Home Health Program coordinators via telephone the following week. The Medicare home health certification forms are not part of the electronic health record (EHR) and are not scanned for placement therein. OMI was told all home health certification forms completed by NPs are submitted to a collaborating physician for signature. The Home Health Program coordinators assured OMI that any improperly completed forms are returned to the appropriate physician for signature. The Medical Center leadership has reviewed the process for Medicare form completion with all clinical staff in Primary Care.

**This action has been completed.**

**Recommendation 18:** The three NPs who have not yet received their individual DEA certificates should be encouraged to obtain these as soon as possible. Until that time, they are not writing prescriptions for controlled substances, and are relying on the collaborating physicians to write these prescriptions as necessary.

**Resolution:** The Medical Center encouraged all NPs to obtain individual DEA certificates. At the time of the original investigation, there were three NPs without their own DEA certificates. Since then, two NPs applied for and have received individual DEA certificates, and one NP has retired. The Medical Center completed and will continually review the spreadsheet containing all information about NP licensure to ensure compliance. On October 22, 2013, the Medical Center's Pharmacy Service reviewed all prescriptions for the preceding 3 months requiring DEA certification and did not find any unauthorized controlled substance prescriptions.

**This action has been completed.**

**Recommendation 19:** The NP functional statement, qualification standards, and dimensions of practice of the Medical Center must be revised to be consistent with national policy per VA Handbook 5005, Appendix G6.

**Resolution:** The NP functional statements, qualification standards, and dimensions of practice have been updated for the Medical Center, consistent with national policy per VA Handbook 5005, Appendix G6 and approved by the Chief Nurse Executive. The Medical Center's clinical service chiefs will ensure service-level specific NP functional statements are completed and filed in each individual NP's competency folder.

**This action has been completed.**

**Recommendation 20:** The Medical Center must complete a clinical care review of a random sample of the patient care records for the NPs who were prescribing controlled substances, outside of the authority granted by their license. This review should focus on patients who actually were prescribed controlled substances. If any clinical issues are identified the review should be expanded.

**Resolution:** Within the 30 patient care records per provider reviewed to address item 14 above, the VISN reviewed NP prescriptions of controlled substances to ensure that their prescribing was clinically appropriate. All prescriptions of controlled substances were found to be appropriate.

**This action has been completed.**

**Recommendation 21:** Medical Center policies and bylaws concerning the practice of NPs should be updated to reflect VA national policies and the licensure and DEA

requirements for this profession. Functional statements should be updated to reflect all current regulations.

**Resolution:** The Medical Center drafted proposed changes to the Medical Center Bylaws. The proposed changes were presented to the Executive Board of the Governing Body for approval prior to presentation to the medical staff. The medical staff approved these changes to the Bylaws October 31, 2013.

**This action has been completed.**

**Recommendation 22:** The Medical Center should review all eight cases identified by Lumetra as having moderate to high assessed impact including all relevant medical records and appropriate subspecialty consultation to determine the degree of harm, if any, and to conduct appropriate disclosures to patients and/or their families in accordance with VHA policy concerning institutional disclosure.

**Resolution:** The VISN has appointed a staff physician from a different facility within VISN 16 to review the eight cases in question alongside the Lumetra data. Following completion of the review, the Medical Center conducted the appropriate disclosures to patients and families and forwarded its findings to the VISN.

**This action has been completed.**

**Recommendation 23.** (b) (6), VHA Chief Consultant, Diagnostic Services, should identify an appropriate number of (b) (6) studies drawn from the period July 2003–November 2007, so that an external peer review can be conducted. The Medical Center, in consultation with (b) (6), should determine any further action if the discrepancy rate is outside the expected baseline.

**Resolution:** (b) (6) has thoughtfully determined that no further cases need to be reviewed. Several reviews have already been completed to assure quality care was provided and the cases have met the standard of care. A review to establish competency by the radiologist, including a study of 300 of his cases, was completed several years ago, and is a large enough sample to identify an incompetent radiologist. To review this radiologist again, especially if he is the only radiologist reviewed, would appear malevolent. To do such a review properly would require reviewing very large numbers of cases from each of the radiologists that worked at the Medical Center to demonstrate that he performed at a lower standard. Furthermore, administrative action is not an option for a former employee, and so many years have passed that VHA could not take legal action.

**This action has been completed.**