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The Special Counsel

July 17, 2015

The President
The White House
Washington, D.C. 20500

Re: OSC File No. DI-14-4002

Dear Mr. President:

Pursuant to my duties as Special Counsel, enclosed please find the Department of Veterans Affairs (VA) report based on disclosures of wrongdoing at the Carl Vinson VA Medical Center (Vinson VAMC), Dublin, Georgia. The Office of Special Counsel (OSC) has reviewed the report and, in accordance with 5 U.S.C. § 1213(e), provides the following summary of the allegations and our findings.

Kathleen Amos, an advanced practice registered nurse (APRN) who consented to the release of her name, disclosed that employees at Vinson VAMC engaged in conduct that may constitute a violation of law, rule, or regulation; and a substantial and specific danger to public health. Specifically, Ms. Amos disclosed that APRNs at Vinson VAMC prescribed prescription drugs without required state licenses.

**The agency substantiated Ms. Amos's allegations in part and recommended a variety of corrective actions. The agency determined that ten APRNs in two departments lacked state prescription authority, but routinely wrote orders for non-controlled substances. The agency further found that no APRNs at the Medical Center licensed in Georgia had approved Nurse Protocol Agreements, in violation of state law. In addition, the report noted that Vinson VAMC leadership knew about these deficiencies but failed to take appropriate action to resolve them. The investigation determined that these violations did not constitute a substantial and specific danger to public health because APRNs at Vinson VAMC had collaborative agreements with VA physicians who supervised the APRNs' practice and co-signed controlled substance prescriptions, and Vinson APRNs had restricted access privileges in electronic systems used to prescribe medications. The report noted that investigators reviewed patient safety records, plus quality and peer reviews for patients treated by APRNs and found no adverse patient care incidents.**

**The report recommended increased levels of documented supervision of APRNs and education for providers and leadership on state licensure requirements,**

**and noted that Vinson VAMC has implemented these recommendations. The report recommended that the Veterans Health Administration (VHA) issue an instructional letter to all medical centers reinforcing the need for compliance with APRN state licensure requirements and recommended administrative action against managers who failed to act promptly to ensure compliance. Based on my review, I have determined that the report meets all statutory requirements and that the findings appear to be reasonable.**

Ms. Amos's allegations were referred to Secretary Robert A. McDonald to conduct an investigation pursuant to 5 U.S.C. §1213(c) and (d). Secretary McDonald asked the Interim Under Secretary for Health to refer Ms. Amos's allegations to the Office of the Medical Inspector for investigation. Chief of Staff Robert L. Nabors II was delegated the authority to review and sign the report, which he submitted to OSC on May 19, 2015. Pursuant to 5 U.S.C. § 1213(e)(1), Ms. Amos provided comments on the agency report on June 9, 2015. As required by 5 U.S.C. § 1213(e)(3), I am now transmitting the report and Ms. Amos's comments to you.

## I. Ms. Amos's Disclosures

VHA directives establish medication prescribing authority for APRNs. Under the VHA directive, an APRN must possess proper state licensure or registration to prescribe medication in a VHA facility. *See* VHA Directive 2008-049 § 2.b. In Georgia, APRNs with prescriptive authority are subject to a two-tiered licensing framework. APRNs must first obtain a nursing license from the Georgia Board of Nursing. Next, licensed APRNs must file a protocol agreement with the Georgia Medical Board. When the Georgia Medical Board certifies a protocol agreement, an APRN is granted prescribing privileges. *See* O.C.G.A. § 43-34-25 and Georgia Board of Nursing Regulation §§ 410-13-.01 and 410-13-.02. Without an approved protocol agreement, a Georgia APRN cannot independently order prescriptions.

According to Ms. Amos, ten APRNs in the Mental Health and Primary Care clinics at Vinson VAMC lacked protocol agreements but routinely prescribed medications independently. A review of the Georgia Composite Medical Board's List of Approved APRN Protocols indicated that at the time of the original OSC referral, these individuals did not have protocol agreements. Ms. Amos explained that she reviewed relevant patient charts and determined that these APRNs routinely entered prescription orders. While Ms. Amos only had personal knowledge regarding the protocol status of the ten APRNs referenced above, she observed that it was likely that APRNs across all Vinson VAMC clinics and service lines lacked protocol agreements, but entered prescription orders regardless.

## II. The Agency Report

The agency determined that Vinson VAMC leadership failed to ensure that APRNs met applicable state protocol agreements. The report explained that Annie Hutchinson, Vinson VAMC's risk manager, informed senior Vinson VAMC leadership of these issues during a two-day meeting of the Medical Executive Committee (MEC) that started on June 18, 2014. This committee included the medical center director and the chief of staff. According to meeting minutes, Ms. Hutchinson explained APRN protocol issues, but no action was taken. On June 19, 2014, Ms. Hutchinson raised the issue again, and meeting minutes indicated the matter was discussed and the committee recognized the need to comply with Georgia licensure requirements. Ms. Hutchinson sent a follow-up email after the meeting to request that the MEC take action.

On June 20, 2014, the supervisor of the Credentialing and Privileging (C&P) Department at Vinson VAMC sent an email to the senior Vinson VAMC leadership indicating that she had prepared packets for APRNs to complete in order to fulfill Georgia licensure requirements. However, the investigation determined that no approval had been given and the actions were never carried out. The report noted that both supervisors and employees had knowledge of the actions required to prevent a violation of state law, but failed to ensure they were taken.

The report made a number of recommendations to correct these deficiencies. For Vinson VAMC, the report noted that the C&P Department must verify that APRNs are adhering to proper state licensure requirements. It recommended the implementation of a process to ensure appropriate monitoring of APRNs' licensure, and indicated that senior leadership should receive education on state licensure requirements. It further suggested that the VA take administrative action against individuals who had knowledge of the state requirements but failed to act promptly to ensure compliance.

The report also recommended that the Veterans Integrated Service Network 7 Quality Management Office take action to verify that VAMCs within their networks follow applicable state guidelines for APRN practice. In addition, the report recommended that VHA issue an instructional letter to all medical centers reinforcing the requirement for compliance with VA national policies concerning APRN credentialing. The report noted that Vinson VAMC has developed a tracking sheet to monitor APRN compliance with Georgia state law, conducted a review of each APRN's compliance with state licensure requirements, and ensured that C&P Department staff and supervisors are trained on these requirements and the use of VA's talent management system.

## III. Ms. Amos's Comments

Ms. Amos disagreed with the discussion of her termination in the report. Specifically, she noted that the way the report was written appeared to suggest that she let

her license lapse, which she asserted is incorrect. Ms. Amos noted that her approval to practice was placed on inactive status because she lost her supervising physician at the time, but that she has never had an inactive license or certification.

**IV. The Special Counsel's Findings**

I have reviewed the original disclosure, the agency report, and Ms. Amos's comments. Notwithstanding Ms. Amos's objections to the discussion of her licensure in the report, I am satisfied that the agency's investigation was sufficient. Based on the VA's report and recommendations contained within, the agency report meets all statutory requirements and the findings of the agency appear reasonable.

As required by 5 U.S.C. § 1213(e)(3), I have sent copies of the agency report and Ms. Amos'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 report and Ms. Amos's comments in our public file, which is available at www.osc.gov. OSC has now closed this file.

Respectfully,

Carolyn N. Lerner

Enclosures