U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 300
Washington, D.C. 20036-4505

The Special Counsel

November 20, 2015

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

Re: OSC File No. DI-13-2396

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 Malcolm Randall VA Medical Center (Medical Center), The Villages Outpatient Clinic (Clinic), Gainesville, Florida. The U.S. 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 agency investigation, whistleblower comments and my findings.

The whistleblower, Susan M. Yeager, former chief of Podiatry at the Clinic, who consented to the release of her name, alleged that a registered nurse in the Podiatry Clinic was operating outside the scope of her authority, electronically entering orders and other information into medical records without review and approval of a physician, and completing Medicare Home Health Care forms that require the signature of a physician. Dr. Yeager also alleged that registered nurses operated outside the scope of their practice, staffed clinics when physicians were unavailable and that the facility was not meeting the demands of the patient population.

The VA Office of the Medical Inspector (OMI) conducted the investigation but did not substantiate the allegations. After review of the information entered into the medical records by the Podiatry Clinic nurse, OMI concluded that she neither exceeded her authority nor improperly used the electronic signature. Further, the investigation did not find evidence of improper practices by nurses in other practice areas, lapses or gaps in physician coverage, or fraud in the approval of Medical Home Health Care referrals. Nevertheless, the OMI recommended policy clarification and training on agency policy and practice expectations. I have determined that the report contains all of the information required by statute and the agency's findings are reasonable.

On February 26, 2014, OSC referred the allegations to then-Secretary of Veterans Affairs Eric K. Shinseki for investigation pursuant to 5 U.S.C. § 1213(c) and (d). Secretary Shinseki asked the Under Secretary for Health to investigate, who tasked the

OMI with the investigation. On June 5, 2014, then-Chief of Staff Jose D. Riojas submitted the agency report to OSC on behalf of the Secretary. Pursuant to 5 U.S.C. § 1213(e)(1), Dr. Yeager submitted comments on the report on December 5, 2014. As required by 5 U.S.C. § 1213(e)(3), I am now transmitting the agency reports and Dr. Yeager's comments to you.[1]

I. Dr. Yeager's Disclosures

Dr. Yeager reported that in May 2012, she noticed that orders and instructions attributed to her were entered into the Computerized Patient Record System (CPRS) while she was on leave. She alleged that the registered nurse at the Podiatry Clinic routinely exceeded the scope of her practice authority through such actions as entering medical information and orders into CPRS, treating patients and signing her name electronically on medical records without her permission, and that she was not in compliance with Medical Center Memorandum (MCM) 118-21, *Protocol Orders for Nurses in Ambulatory and Outpatient Clinics.* She further alleged that the nurse was not in compliance with MCM 136-1, *Telephone and Verbal Orders*, because the medical records included telephone orders that Dr. Yeager did not authorize, and the nurse did not seek approval for those orders as required. Additionally, Dr. Yeager alleged that the nurse entered medical orders using the electronic signature under the name of Dr. Kenneth Donahue, chief medical officer.

Dr. Yeager also contended that other nurses exceeded the scope of their practice. She reported that when a Primary Care physician left the facility in April 2013, a registered nurse assumed responsibility for her patients, including seeing patients, ordering tests, and writing diagnoses without the supervision of a physician. Dr. Yeager observed the nurse running the practice from April–July 2013. She reported that during the absence of a second Primary Care physician from January–March 2013, a registered nurse treated her patients, ordered tests, and wrote diagnoses. Dr. Yeager stated that she regularly observed these nurses working without the supervision of physicians and contended they were in violation of MCM 118-21.

Dr. Yeager maintained that nurses often staff clinics and function as doctors in order to fill physician staffing gaps, thus raising concern about the apparent lack of physician

---

[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). 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).

oversight at the facility and suggesting that the staffing level of physicians may be insufficient to meet the demands and needs of the patient population. Finally, Dr. Yeager alleged that the nurses' actions could constitute Medicare fraud because physicians must sign orders and evaluations for home health care.

II. The Agency Report

The report describes the Clinic as an outpatient facility that provides a wide variety of medical services such as primary care, dental and optometry, as well as specialty care including cardiology, gynecology, dermatology and podiatry. The Podiatry Clinic, staffed by a podiatrist, registered nurse and clerical personnel, provides a number of services including prescriptions, orthopedic devices, excisional debridement, minor invasive procedures and routine nail care and trimming. In FY 2013 the Podiatry Clinic provided care to 408 veterans for a total of 587 clinic appointments.

The report explains that the Veterans Health Administration (VHA) created Patient Aligned Care Teams (PACT) to provide veterans with patient-centered, team-based, comprehensive and coordinated primary care. Under this model, set forth in VHA Handbook 1101.10 *Patient Aligned Care Team Handbook*, registered nurses are expected to function at the highest level permitted by their nursing license and agency policy. They participate in patient care and communication in a number of ways, including shared medical appointments, view alerts management, telephone care, secure messaging, clinical video telehealth and face-to-face visits. Registered nurses are also responsible for collaborating with technical personnel to develop standardized tools to support the PACT process, such as pre-visit reminder calls and primary care protocols for chronic disease management.

The Medical Center and the Clinic have PACT protocols that serve as guidelines for nursing practice and PACT nurses are expected to enter orders based on protocols in accordance with MCM 118-21. The report notes that although the *Podiatry RN Scope of Practice/Roles and Responsibilities* does not identify which orders and consultations nurses are allowed to enter, it does provide that the nurse is responsible for entering consults/orders according to the *Outpatient Clinic Nursing Guidelines*, which in turn references MCM 118-21. The report goes on to state that MCM 118-21 authorizes outpatient registered nurses to enter orders and consultations in order to manage care more efficiently.

The report describes the three-step process for entering orders into CPRS. All orders have the name of the individual entering the order and the name of the licensed independent provider, such as the physician or dentist, responsible for requesting or authorizing the order. Under the PACT protocols, registered nurses may enter some orders. The signature section displays the name of the person who entered and signed the order and shows that the order was signed, "On Chart with written orders," indicating that the provider's note contains the supporting information for the order. When the registered

nurse enters the order, the documentation indicates the order is within the approved protocols.

The report explains that in the Podiatry Clinic, the accepted clinical practice was for the podiatry nurse to write down the podiatrist's comments and findings as the podiatrist conducted the examination. The report acknowledges that there were no written protocols in place for the Podiatry Clinic; however, it states that verbal protocols were established prior to the opening of the Clinic. Dr. Yeager maintained that she asked the nurse to stop entering and releasing orders. In contrast, the nurse reported that she was trained to enter orders and consultations, in addition to other duties, and that Dr. Yeager never instructed her to stop entering orders or consultations.

OMI investigators selected for review a random sample of 445 of the 1232 orders and consultations that the Podiatry nurse entered. In 392 of the cases, the documentation showed that the item or service that the nurse ordered was part of the podiatrist's plan of care for the patient. Further, the investigation found that most of the notes that the nurse wrote indicate that the podiatrist was present during the patient appointment. The investigation determined that all orders were entered and signed by the Podiatry nurse in CPRS with a notation that the provider's request for either the item or service was documented in the provider's note and signed, "On Chart with written orders." Dr. Yeager was identified as the provider, but the orders did not include her electronic signature. Based on that review, OMI concluded that the items or services entered by the nurse were included in the podiatrist's plan of care for the patients and that she did not sign the records using Dr. Yeager's electronic signature. Subsequently, the agency reviewed the approximately 700 remaining orders. In August 2015, the VA advised that this additional review identified two orders for appointments that lacked documentation by the podiatrist. This finding did not change the investigative findings.

OMI also investigated whether nurses in other practice areas were operating outside their scope of authority. Interviews with PACT and specialty nurses reflect that nurses only entered orders in CPRS pursuant to MCM 118-21. PACT physicians interviewed did not report any concerns with nurses entering orders and consultations, and were not aware of inappropriate entries by nurses.

With respect to the allegation that nurses staffed clinics and treated patients when physicians were unavailable, the report notes that several nurses and physicians described a standard practice of assigning surrogate physicians to the patients of physicians who were unavailable due to planned or unplanned absences. The investigators reviewed the patient panels of the two physicians whose patients Dr. Yeager alleged were treated by nurses in their absence. In the case of the first physician, the investigation found that the physician's clinic schedule was cancelled from April 8, 2013, through May 20, 2013, resulting in the rescheduling of 186 of the 221 appointments. The patients scheduled for the remaining 35 appointments were seen by other providers on the day of their scheduled appointment. OMI confirmed that for the 35 patients seen by surrogate

providers, a physician entered a progress note in the medical records describing the care provided. The pending retirement of the second physician resulted in the cancellation of 20 appointments from May 28, 2013, through July 1, 2013. The patients were rescheduled with other providers and, again, OMI's review of the medical records verified that physicians entered progress notes for the rescheduled appointments regarding the care provided to the veterans.

OMI also reviewed the level of physician staffing at the clinic between January 2011 and January 2014 and concluded the staffing was adequate, noting that clinic leadership monitors physician staffing to ensure that the facility meets the needs of the patient population. Finally, investigators reviewed all Medicare Home Health Program referral forms initiated by the Podiatry Clinic between January 2011 and March 2013 and determined that all forms were signed by a physician as required.

Agency Action Proposed

OMI recommended that the Medical Center review and revise the *Podiatry RN Scope of Practice/Roles and Responsibilities* to clarify the guidance for specialty nurses entering orders and consultation requests. Additionally, OMI recommended training on any revised policy, and that the new employee orientation for nurses and providers emphasize order and consultation entry procedures and expectations under MCM 118-21. Finally, OMI recommended that compliance with the podiatry policy and MCM 118-21 be monitored and any non-compliance reviewed and addressed.

III. The Whistleblower's Comments

Dr. Yeager described her medical expertise in limb preservation and wound care and professional experiences working at VA hospitals for approximately 11 years. She explained that she chose a career in medicine after the tragic fire that claimed the lives of her two brothers and caused her sister to undergo numerous surgeries and rehabilitation.

Dr. Yeager also recounted her experiences as a whistleblower at the VAMC in Jackson, Mississippi. Based on her experiences, Dr. Yeager believes that management at VA facilities goes to any length necessary to ensure that performance measures are met so that management officials receive bonuses. She continues to believe that management allowed nursing staff to forge her signature on medical records in order the meet agency performance measures and receive bonuses. Dr. Yeager noted her belief that in response to a backlog of at least 360 consults, appointments were cancelled and a paper list of patients maintained resulting in patients not being seen.

Dr. Yeager noted that she paid a heavy price in terms of retaliation and harassment from coworkers and officials at the VA. She commented that because she no longer works at the VA, she can speak with candor. Finally, she hopes VA officials will be held accountable and that service to veterans will improve.

IV. The Special Counsel's Findings

I have reviewed the original disclosure, the agency report, and the whistleblower's comments. Based on that review, I have determined that the report contains all of the information required by statute. I have also found reasonable the agency's conclusions.

I thank Dr. Yeager for bringing her concerns regarding the Jackson VAMC, reviewed in another OSC matter, and those identified at the Medical Center in this case, to OSC's attention. Her dedication to veterans is evident through her actions.

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 Dr. Yeager'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.