



DEPARTMENT OF VETERANS AFFAIRS  
WASHINGTON DC 20420

October 28, 2015

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

RE: OSC File No. DI-15-3037

Dear Ms. Lerner:

I am responding to your letter regarding allegations made by a whistleblower at the G.V. (Sonny) Montgomery Department of Veterans Affairs (VA) Medical Center, (hereafter, the Medical Center) located in Jackson, Mississippi. A Nurse Practitioner (NP) there charged that her monitoring by a supervising physician never took place and that the general monitoring of NPs at the Medical Center was inadequate, resulting in a violation of law, VA directives, and a substantial and specific danger to public health. The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary as referenced in 5 United States Code § 1213(d)(5).

The Interim Under Secretary for Health directed the Office of the Medical Inspector to assemble and lead a VA team to conduct an investigation. The report substantiates the first allegation, does not substantiate the second, and partially substantiates the third. The report makes five recommendations to the Medical Center to determine responsibility for monitoring the NP's practice, to establish clear guidelines for monitoring, to review both the current system of monitoring and its compliance with VHA Directive 2010-025, *Peer Review for Quality Management*, to ensure training for all newly assigned PC providers, and to assess accountability for the lack of monitoring of the NP's practice and take corrective action. We will send your office follow-up information describing actions that have been taken by the Medical Center to implement these recommendations.

Thank you for the opportunity to respond.

Sincerely,

A handwritten signature in blue ink, appearing to read "Robert L. Nabors II".

Robert L. Nabors II  
Chief of Staff

Enclosure

**DEPARTMENT OF VETERANS AFFAIRS  
Washington, DC**

**Report to the  
Office of Special Counsel  
OSC File Number DI-15-3037**

**Department of Veterans Affairs  
G.V. (Sonny) Montgomery VA Medical Center  
Jackson, Mississippi**



**Report Date: October 26, 2015**

**TRIM 2015-D-5109**

## Executive Summary

The Interim Under Secretary for Health (I/USH) requested that the Office of the Medical Inspector (OMI) assemble and lead a VA team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the G.V. (Sonny) Montgomery Veterans Affairs (VA) Medical Center (hereafter, the Medical Center) located in Jackson, Mississippi. **Whistleblower** (hereafter **Whistleblower**), who is an advanced practice nurse practitioner (NP) and former employee, made allegations that during the time she practiced at the Medical Center, she was not appropriately supervised and did not have a relationship with any collaborative physician, as required by state regulations. Based on this allegation, OSC has determined that there is a substantial likelihood that employees have violated laws, rules, or regulations; engaged in gross mismanagement; and/or created a substantial and specific danger to public health and safety. The VA team conducted a site visit to the Medical Center on July 14-16, 2015.

### Specific Allegations of the Whistleblower:

1. **Whistleblower** assigned collaborative physician did not appropriately monitor her practice at the Jackson VAMC.
2. Director, **Director** Chief of Staff **Chief of Staff** and Chief of Primary Care **Service** **Service** have not ensured that collaborative physicians are appropriately monitoring each NP's practice, despite the VA's prior assurances that the Jackson VAMC is in compliance with state collaboration requirements; and,
3. **Director** **Chief of Staff** **Service Chief** and **Whistleblower** collaborative physicians caused a substantial and specific danger to public health or safety by failing to ensure that collaborative physicians are appropriately monitoring each NP's practice.

VA **substantiated allegations** when the facts and findings supported that the alleged events or actions took place and **did not substantiate allegations** when the facts and findings showed the allegations were unfounded. VA was **not able to substantiate allegations** when the available evidence was not sufficient to support conclusions with reasonable certainty about whether the alleged event or action took place.

After careful review of findings, VA makes the following conclusions and recommendations.

### Conclusions for Allegation 1

- VA **substantiated** that **Whistleblower** assigned collaborative physician did not work with her during her employment at the Medical Center. Collaborative practice is designed to monitor the practice of the NP through direct supervision (in the case of real-time consultation), and indirect supervision through retrospective medical record reviews. Within VA, additional review is provided through the on-going monitoring of clinical practice under the FPPE/OPPE processes to confirm the quality of care delivered.

- Although a primary collaborative physician and five alternates were assigned to Whistleblower on paper, her primary collaborative physician was not notified or aware of her assignment. Whistleblower had no contact with her primary collaborative physician until May 26, 2015, — after she had been removed from clinical duties.
- VA concluded that Whistleblower violated Mississippi Nursing Practice Law, section 73-15-20(f), and the Mississippi Board of Nursing Administrative Code, Title 30, Part 2840, Chapter 2, Rule 2.3.C.3)(a), (b) and (c) s by failing to ensure that her practice was appropriately monitored by her physician collaborators in accordance with her state licensure requirements. Whistleblower is responsible for complying with applicable licensure requirements.
- VA concluded that the Medical Center assigned a primary collaborating physician to oversee Whistleblower clinical practice but failed to ensure that the primary collaborating physician was aware of the assignment and appropriately monitored Whistleblower clinical practice, in accordance with her state licensure requirements.
- VA concluded that another NP's name entered on Whistleblower Focused Professional Practice Evaluation (FPPE) was an indication of poor administrative oversight, and might raise questions about the accuracy of the information.
- VA concluded that the Medical Center failed to provide Whistleblower with an adequate orientation.

### **Recommendations to the Medical Center**

1. Determine who was responsible for failing to ensure that Whistleblower clinical practice was appropriately monitored by her primary collaborating physician, in accordance with Mississippi law, and take appropriate educational, administrative, and/or disciplinary action.
2. Establish clear written procedures to ensure that all newly assigned NPs are introduced to their collaborative physicians, and that assigned collaborative physicians establish working relationships with the NPs assigned to them.
3. Review the current system of documenting the monitoring of NPs who are not LIPs, and make changes as needed to ensure appropriate monitoring.
4. Review the Medical Center's compliance with VHA Directive 2010-025, *Peer Review for Quality Management*. Review the Medical Center's FPPE/OPPE processes to ensure compliance with VHA policy.
5. Ensure that all newly assigned Primary Care (PC) providers receive a complete, step-by-step orientation, allowing sufficient time to learn the CPRS and to become familiar with the collaboration process.

## Conclusions for Allegation 2

- VA **did not substantiate** that the Medical Center leadership failed to ensure that collaborative physicians are appropriately monitoring each NP's practice, other than that of the whistleblower. Under VHA policy, NPs who are not LIPs per their state licensure are required to practice within a specialty area or primary care in collaboration with a qualified physician(s) and in accordance with a written scope of practice (SOP). The purpose of collaboration is to review the practice of the NP, both formally and informally, through both direct supervision in the case of real-time consultation, and indirect supervision through retrospective medical record reviews. Additional review is provided through the on-going monitoring of clinical practice under the FPPE/OPPE processes to confirm the quality of care delivered.
- All other NPs employed at the Medical Center established formal agreements with collaborative physicians, and their practices are appropriately monitored by their assigned collaborative physician and by the appropriate clinical leader, such as the Acting Chief of Service, PC (ACoS, PC).

## Recommendation to the Medical Center

None.

## Conclusions for Allegation 3

- VA **partially substantiated** this allegation. We determined that although the Medical Center management is ensuring that collaborative physicians are appropriately meeting the Mississippi state requirements for collaboration and are currently following the local and VHA policies and directives for collaboration, it did not do so for **Whistleblower**.

## Recommendation to the Medical Center

See Recommendation 1.

## Summary Statement

OMI has developed this report in consultation with other Veterans Health Administration (VHA) and VA offices to address OSC's concerns that the Medical Center may have violated law, rule, or regulation; engaged in gross mismanagement and abuse of authority; or created a substantial and specific danger to public health and safety. In particular, the Office of General Counsel (OGC) has provided a legal review, and the Office of Accountability Review (OAR) has examined the issues related to accountability of senior leadership. VA found violations of VHA policy and Mississippi state law.

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## I. Introduction

The I/USH requested that OMI assemble and lead a VA team to investigate allegations lodged with OSC concerning the Medical Center located in Jackson, Mississippi. **Whistleblower** an NP and former employee, made allegations that during the time she practiced at the Medical Center, she was not appropriately supervised and did not have a relationship with any collaborative physician, as required by state regulations. Based on this allegation, OSC has determined that there is a substantial likelihood that employees have violated laws, rules, or regulations; engaged in gross mismanagement; and/or created a substantial and specific danger to public health and safety. The VA team conducted a site visit to the Medical Center on July 14–16, 2015.

## II. Facility Profile

Part of Veterans Integrated Service Network (VISN) 16, the Medical Center's primary service area serves more than 125,000 Veterans; treats approximately 45,000 unique patients and has more than 300,000 outpatient visits annually. It provides primary, secondary, and tertiary medical, neurological, and mental health inpatient care, and operates a 120-bed Community Living Center. The Medical Center's services include radiation therapy, magnetic resonance imaging, hemodialysis, cardiac catheterization, sleep studies, substance abuse treatment, and post-traumatic stress disorder (PTSD), hematology/oncology, and rehabilitation programs. Both primary and specialized outpatient services are available, including such specialized programs as: ambulatory surgery, spinal cord injury, neurology, infectious disease, substance abuse, PTSD, readjustment counseling, and mental health diagnostic and treatment programs. Comprehensive health care is available for female Veteran patients. To support its health education and physician residency programs, the Medical Center has affiliations with the University of Mississippi Medical Center, Alcorn State University, and three community colleges.

The Medical Center's Primary Care (PC) Service consists of the primary care clinic (PCC), community-based outpatient clinics (CBOC), telehealth, women's health, community wellness, home health, and outreach. The PCC is located in Jackson, Mississippi, and the outpatient clinics are located in Hattiesburg, Meridian, Kosciusko, Greenville, Natchez, Columbus, and McComb, Mississippi. The PCC has five patient care aligned teams (PACT): Green, Blue, Silver, Purple, and Pink.

## III. Specific Allegations of the Whistleblower

1. **Whistleblower** assigned collaborative physician did not appropriately monitor her practice at the Jackson VAMC Medical Center.
2. The Director, **Director** Chief of Staff, **Chief of Staff**; and Chief of Primary Care (PC), **Service Chief PC** MD, have not ensured that collaborative physicians are appropriately monitoring each NP's practice, despite VA's prior assurances that the Jackson VAMC is in compliance with state collaboration requirements; and

3. The Director, CoS, Chief of PC, and **Whistleblower** collaborative physician caused a substantial and specific danger to public health or safety by failing to ensure that collaborative physicians are appropriately monitoring each NP's practice.

#### IV. Conduct of Investigation

The VA team conducting the investigation consisted of **Team Member #1** MD, Senior Medical Investigator (an internist) and **Team Member** RN, Clinical Program Manager, both of OMI; **Team Member #3** DNP, FNP-C, Liaison for National APRN Policy, VHA Office of Nursing Service; and **Team Member** Chief, Employee Relations/Labor Relations HR Specialist, Greater Los Angeles Healthcare System. The team reviewed relevant policies, procedures, professional standards, reports, memorandums, and other documents listed in Attachment A. We conducted a face-to-face interview with **Whistleblower** in Jackson from 5:30 p.m. to 7:00 p.m. on July 13, 2015. She reiterated her concerns identified in her OSC letter and provided additional names of employees she wanted interviewed; we interviewed all of them.

We held entrance and exit briefings with Medical Center and VISN 16 leadership. The following employees attended the Entrance Briefing:

- **Acting CMO** DNP, Acting Chief Medical Officer (CMO), VISN 16
- **Director** Medical Center Director
- **Chief of Staff** MD, Chief of Staff (CoS)
- **Acting AD** Acting Associate Director
- **Assistant Director** Assistant Director
- **Associate Director** Associate Director Patient Care Services (ADPCS)
- **Service Chief** Chief, Quality Management (QM)

We also interviewed the following Medical Center employees:

- **Director** Medical Center Director
- **Chief of Staff** MD, CoS
- **Associate Director** ADPCS
- **Service Chief** Chief, QM
- **Employee #2** Credentialing and Privileging (C&P) Supervisor
- **Employee #3** Executive Assistant to ADPCS
- **Service Chief PC** MD, Assistant CoS, Primary Care (ACoS, PC)
- **Employee #4** Administrative Officer (AO), PC
- **Employee #5** MD, PC Purple Clinic
- **Employee #1** MD, PC Silver Clinic
- **Employee #6** MD, PC Blue Clinic
- **Employee #7** MD, PC Green Clinic
- **Employee #8** MD, PC Green Clinic
- **Employee #9** MD, PC Blue Clinic

- Employee #10 MD, PC Silver Clinic
- Employee #11 NP, PC Green Clinic
- Employee #12 MD, PC Pink Clinic
- Employee #13 MD, PC Green Clinic
- Employee #14 NP, PC Purple Clinic
- Employee NP, Compensation and Pension Clinic
- Employee #16 NP, Pulmonary/Cancer Care
- Employee #17 NP, PC Silver Clinic
- Employee #18 NP, Orthopedics
- Employee #19 NP, Gastroenterology (GI)
- Employee #20 NP (formerly assigned to the PC Purple Clinic)
- Employee #21 NP, Neurology
- Employee #22 NP, Women's Health Coordinator, PC Pink Clinic
- Employee #23 NP, Nursing Service Operation Iraqi Freedom/Operation Enduring Freedom
- Employee #24 NP, Mental Health
- Employee #25 NP, Emergency Department
- Employee #26 NP, PC Green Clinic

The following employees attended the Exit Briefing:

- Acting CMO DNP, Acting CMO, VISN 16
- Director Medical Center Director
- Chief of Staff MD, CoS
- Associate Director ADPCS
- Service Chief Chief, QM
- Employee #27 Assistant Chief, QM

## Background

NPs are advanced practice registered nurses (APRN), health care providers who have received specialized education and achieved a high level of clinical competency, enabling them to provide health and medical care for diverse populations in a variety of inpatient and outpatient settings.

The NP Scope of Practice typically includes blending nursing and medical services for individuals, families, and groups. They diagnose and manage acute and chronic conditions, emphasizing health promotion and disease prevention. Their services may include, but are not limited to: ordering, conducting, and interpreting diagnostic and laboratory tests; prescribing pharmacologic agents and nonpharmacologic therapies; and teaching and counseling. NPs may practice both autonomously and in collaboration with other health care professionals to manage patients' health needs.

## **APRN Licensure and Collaborative Agreements**

In 21 states and the District of Columbia, NPs practice without any requirement for collaboration with, or supervision by, a physician, but in Mississippi, and many other states, the collaborative agreement requirements are more restrictive. (See Appendix B.)

In Mississippi, the practice of Advanced Nursing is governed by the Mississippi Nursing Practice Law, Mississippi Code Annotated 73-15-1, et seq., and the Mississippi Board of Nursing's regulations, Mississippi Administrative Code, Title 30, Part 2840. These laws require an APRN to practice in a collaborative/consultative relationship with a physician or dentist who has an unrestricted license to practice in the state. Miss. Code Ann. 73-15-20(3). Advanced nursing must be performed within the framework of a standing protocol or practice guidelines, as appropriate, that is filed with the Mississippi State Board upon license application, license renewal, after entering into a new collaborative/consultative relationship, or when making changes to the protocol, practice guidelines, or practice site.<sup>1</sup> The board shall review and approve the protocol to ensure compliance with applicable regulatory standards. The NP may not practice as an APRN if there is no collaborative/consultative relationship with a physician or dentist and a board-approved protocol or practice guidelines in place. NPs must practice according to a board-approved protocol that has been mutually agreed upon by the NP and a Mississippi licensed physician or dentist whose practice or prescriptive authority is not limited as a result of voluntary surrender or legal/regulatory order.

Further, each collaborative/consultative relationship – must include and implement a formal quality assurance/quality improvement program that is maintained on site and available for inspection by representatives of the board. Miss. Code Ann. 73-16-20(7)(f) This quality assurance/quality improvement program must be sufficient to provide a valid evaluation of the practice and be a valid basis for change.

Additional practice requirements are contained in 30 Miss. Admin. Code Part 2840, Chapter 2, Rule 2.3.A., B. and C.2), which requires an APRN to practice (1) according to standards and guidelines of their national certification organization; (2) in a collaborative/consultative relationship with a Mississippi-licensed physician whose practice is compatible with that of the APRN; and (3) according to a board-approved protocol which has been mutually agreed upon by the APRN and the physician collaborator. The quality assurance improvement program criteria consist of:

- Review by collaborative physician of a sample of charts that represent 10 percent or 20 charts, whichever is less, of patients seen by the advanced practice registered nurse every month.
- The APRN shall maintain a log of charts reviewed which includes the identifier for the patients' charts, reviewers' names, and dates of review.

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<sup>1</sup> The terms "standing protocol or practice guidelines" (used by the State of MS) and "(nursing) Scope of Practice" (used by VA) are used synonymously. Many different kinds of health care professionals, including nursing assistants, RNs, APRNs, and physicians, have defined scopes of practice.

- Each advanced practice registered nurse shall meet face to face with a collaborating physician once per quarter for the purpose of quality assurance.

According to the Medical Center's policy, "Utilization of APRNs in Collaborative Practice," an APRN licensed in Mississippi will function within a specialty area or in primary care in collaboration with a qualified physician and in accordance with a written Scope of Practice, which is determined by his or her education and certification. A collaborative physician is defined as a staff physician who agrees to be available to the NP for consultation and referral. The collaborative physician is required to ensure that management of patient care by the NP is monitored and evaluated regularly. (APRNs licensed in states that do not require collaborative practice may function as licensed independent practitioners (LIP), are granted clinical privileges as such, and do not require a nursing Scope of Practice.)<sup>2</sup>

### **Medical Center Collaborative Agreement Requirements**

There are currently 11 NPs assigned to PC, but only 4 of them have Mississippi licenses requiring a Scope of Practice. These NPs are assigned a primary collaborative physician, as well as alternate collaborative physicians, by the Chief of PC. All collaborative physicians are identified in a document outlining the NP's Scope of Practice. The collaborative physician agrees to review the practice of the NP, both formally and informally, through both direct supervision in the case of real-time consultation, and through indirect supervision in the form of retrospective medical record reviews. These activities promote a program of quality assurance. The supervising Service Chief (in this case, the Chief, PC Services) is responsible for ensuring that such reviews are conducted and that appropriate corrective action is taken when indicated.

The NP and collaborative physician (or alternate) shall be able to have daily contact, in person or by telephone, regarding patient care activities. The collaborative physician and NP must meet monthly to discuss the review being conducted, to record further discussions, and to complete a patient log, as mandated by the state of Mississippi. The log must be signed, indicating that a quality assurance discussion occurred regarding the charts reviewed or other patient care concerns. The signed document is to be forwarded to the CoS' office before the 20<sup>th</sup> of the following month. The collaborating physician must provide input regarding the NP's proficiency annually, in consultation with the NP's supervisor.

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<sup>2</sup> Privileging or Clinical Privileging. Defined as the process by which a practitioner, licensed for independent practice (i.e., without supervision, direction, required sponsor, preceptor, mandatory collaboration, etc.), is permitted by law and the facility to practice independently, to provide specified medical or other patient care services within the scope of the individual's license, based on the individual's clinical competence as determined by peer references, professional experience, health status, education, training, and licensure. Clinical privileges must be facility-specific, practitioner-specific, and within available resources. VHA HANDBOOK 1100.19, *Credentialing And Privileging*, October 15, 2012. [http://www.va.gov/vhapublications/ViewPublication.asp?pub\\_ID=2910](http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2910)

## Ongoing Professional Practice Evaluation/Focused Professional Practice Evaluation (OPPE/FPPE) and NPs<sup>3</sup>

VA is required to ensure that all members of the privileged professional staff demonstrate competency through a series of OPPEs and FPPEs, tools that work together to help determine whether the care delivered by a practitioner falls below an acceptable level of performance. As clinical providers, NPs must be included in the OPPE/FPPE process, regardless of the state of their licensure. VHA uses these tools to monitor all providers' abilities to provide safe, high-quality patient care. All newly-appointed providers are placed on an FPPE for the first few months (typically 90 days) after joining a hospital's medical staff. This initial period of FPPE, upon satisfactory completion, would be transitioned over to the OPPE process, which is required to occur every 6 months. These clinical reviews are ongoing in tandem with any required clinical practice reviews conducted by a collaborating physician, and the supervisory reviews required during an employee's "probationary period" (which all Federal employees (including VHA providers) must complete satisfactorily).

## VI. Findings, Conclusions, and Recommendations

### Allegation 1

**Whistleblower** assigned collaborative physician did not appropriately monitor her practice at the Medical Center.

### Findings

#### Collaborative Agreements

We interviewed the ACoS, PC, and questioned her about the physician collaborative agreements. She said that prior to 2013, PC physicians at the Medical Center did not want to collaborate with NPs. At that time, the PC department was comprised of 17 NPs and 2 physicians. Currently, PC staffing is balanced with a 1:1 ratio of physicians to NPs. As such, the physicians may share the responsibility of providing collaborative reviews of the NPs' practice. Additionally, physicians receive incentive performance pay in exchange for agreeing to serve as collaborative physicians. As a result, most of the physicians are currently in collaborative agreements with NPs who are licensed in states, such as Mississippi, that require them to have such agreements. The ACoS, PC also said that all NPs with collaborative agreements now collaborate and consult with

<sup>3</sup> OPPE - The ongoing monitoring of privileged practitioners and providers to confirm the quality of care delivered and ensure patient safety. Activities such as direct observation, clinical discussions, and clinical pertinence reviews, if documented, can be incorporated into this process. Information and data considered must be practitioner or provider specific, and could become part of the practitioner's provider profile analyzed in the facility's on-going monitoring. FPPE refers to an evaluation of privilege-specific competence of a practitioner or provider who does not have current documented evidence of competently performing requested privileges. FPPE occurs at the time of initial appointment and prior to granting new or additional privileges. FPPE may also be used when a question arises regarding a currently privileged practitioner or provider's ability to provide safe, high-quality patient care (see VHA Handbook 1100.19). VHA Directive 2010-025, *Peer Review For Quality Management*, June 3, 2010. [http://www.va.gov/vhapublications/ViewPublication.asp?pub\\_ID=2910](http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2910)

physicians on a daily basis, and that the facility now requires new physicians to participate in collaboration agreements applicable.

The ACoS, PC, said NPs who are licensed in states that require a collaborative agreement with a physician are assigned one primary and several alternate collaborative physicians during the credentialing phase of the hiring process. NPs are informed that they must contact and develop such a relationship with their assigned physician(s) to meet state licensing board requirements.

When we asked the ACoS, PC, who was responsible for ensuring that collaborative chart reviews were completed, she acknowledged that it is ultimately her responsibility, and that each NP also has an obligation — as specified in his/her Scope of Practice — to make sure this is accomplished. A Mississippi-licensed collaborating physician who fails to perform his/her collaborative/consultative duties, may be subject to disciplinary action by the Mississippi Board of Medicine. We were told that during the credentialing process, NPs are given the names of their primary and alternate collaborative physicians and that those names are recorded on the NP's Scope of Practice document. The PC administrative officer then obtains each collaborative physician's signature on the NP's Scope of Practice, whereupon the NP electronically submits the document with signatures to the state board of nursing. According to the PC administrative officer, the signature of [Whistleblower] primary collaborative physician was not obtained due to an administrative oversight.

The Scope of Practice must also be signed by the ADPCS/Nurse Executive. All NPs must know the names of their collaborative physicians prior to reporting for duty at the Medical Center, because they must submit a signed Scope of Practice to the state licensing board before they can be allowed to perform clinical duties. The state, in turn, must issue the approved Scope of Practice to the Medical Center.

The ACoS, PC, also said that standard practice is for the NP to provide a list of 20 patients to the collaborative physician to review monthly. The physician is required to document his/her comments on a template and discuss the patients' care with the NP, noting any discrepancies or areas for improvement. The NP must obtain the physician's comments and submit the names of the patient charts reviewed to Nursing Service, as a matter of record. When asked if this process had been followed with [Whistleblower] the ACoS, PC, said that [Whistleblower] assigned collaborative physicians had not worked with her until March 20, 2015, the day [Whistleblower] was removed from clinical duties.

VA also interviewed [Employee #1], the PC physician designated on [Whistleblower] Scope of Practice as her primary collaborative physician. [Employee #1] said that she had never worked with [Whistleblower], and was not aware that she had been assigned as her collaborative physician until she received an email from [Whistleblower] on May 26, 2015. In this email, addressed to all PC providers, [Whistleblower] stated, "I am particularly sorry I never met you, as you have been documented as my collaborating physician since I began." [Employee #1] said that she thought the email was strange, since she had never met [Whistleblower] and wouldn't know her if she saw her. [Employee #1] also said

that she had collaborative relationships with two other NPs when she worked in the PC Silver Clinic, and both had contacted her to discuss chart reviews. She had the NPs agree to the number of patient charts they would pull weekly for her to review, because she preferred to look at a few charts a week, instead of 20 at one time, given that she had a panel of approximately 1,300 patients.

We also talked with the Credentialing and Privileging (C&P) supervisor, who said that paper copies of the physician collaborative chart reviews are currently maintained by the Associate Director for Patient Care Services (ADPCS). However, she said that she would be assuming this responsibility within the office of the CoS, and that she is planning to enter chart reviews on a SharePoint site, which would then "drop the reviews into each NP's file; so if you wanted to see, you could just go to the SharePoint." She told us that she thought this new process would be easier to monitor.

When we reviewed the Medical Center's documentation on all NPs with collaborative physician agreements, as well as the corresponding chart reviews, we found that no collaborative physician chart reviews had been completed on [Whistleblower] patient records, but all other NPs' chart reviews had been completed in accordance with Mississippi law.

## VA Employment

[Whistleblower] is an APRN licensed in Mississippi. On October 21, 2014, as part of the credentialing process that occurs prior to hiring, she submitted a Scope of Practice to the Credentialing and Privileging Officer that included a collaborative agreement. This agreement was signed by [Whistleblower] five alternate collaborative physicians, and the ADPCS. Although her primary collaborative physician's name, [Employee #1] was typed on the document, [Employee #1] never signed the agreement because she was unaware of her assignment as [Whistleblower] primary collaborative physician. [Whistleblower] informed us that she never communicated with [Employee #1] while employed at the Medical Center, although she said that she consulted one of her assigned alternate collaborative physicians to discuss one clinical case during her employment. The ACoS, PC, also told us that [Whistleblower] and [Employee #1] were not introduced to each other at the time of [Whistleblower] hiring. The collaborative agreement form, which lacked the primary collaborative physician's signature, was submitted to the state of Mississippi.

Under Miss. Code Ann. § 73-15-20(7)(b),(c) and (f), [Whistleblower] is required to practice:

- In a collaborative/consultative relationship with a licensed physician whose practice is compatible with that of the nurse practitioner. The nurse practitioner must be able to communicate reliably with a collaborating/consulting physician or dentist while practicing.
- According to a board-approved protocol or practice guidelines.

- Each collaborative/consultative relationship shall include and implement a formal quality assurance/quality improvement program which shall be maintained on site and shall be available for inspection by representatives of the board. This quality assurance/quality improvement program must be sufficient to provide a valid evaluation of the practice and be a valid basis for change, if any.

As provided by 30 Miss. Admin. Code Part 2840, Chapter 2, Rule 2.3.C.3), the quality assurance improvement program must consist of:

- Review by collaborative physician of a sample of charts that represent 10 percent or 20 charts, whichever is less, of patients seen by the advanced practice registered nurse every month.
- The APRN shall maintain a log of charts reviewed which includes the identifier for the patients' charts, reviewers' names, and dates of review.
- Each advanced practice registered nurse shall meet face to face with a collaborating physician once per quarter for the purpose of quality assurance.

## Orientation

On October 27, 2014, [Whistleblower] accepted a position at the Medical Center as an NP in PC, and began working in the PC's Green Clinic 5 days later. During the next 2 weeks she completed the Medical Center's general orientation program. After completing general orientation, she began orientation to Primary Care and was assigned to observe the practice of another NP who also worked in the Green Clinic, whom we will refer to as [NP].

Our review of the documentation revealed that [Whistleblower] officially began seeing patients assigned to [NP] panel on November 17, 2014. Initially, she saw patients alongside [NP], a practice commonly referred to as "shadowing," then 3 to 4 patients on her own daily, followed by 6 to 8 patients on her own daily in December 2014. During the time that [Whistleblower] shadowed [NP] which ended in December, [NP] said that they spent time reviewing VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook*, secure messaging, and navigation of the computerized patient record system (CPRS). [NP] said that she tried getting [Whistleblower] to focus on the basics of CPRS, which was important for a new provider to learn, but that [Whistleblower] progressed slowly. [NP] who had accepted a new position in the Gastroenterology (GI) Clinic, told us that before she was transferred, she had informed the ACoS, PC that [Whistleblower] was not ready to be released from orientation. The ACoS, PC's response was that she had planned to allow [Whistleblower] to see a maximum patient load of 6 to 8 patients per day, although she was not sure how many unscheduled patients she would also have to see. Due to the fact that [Whistleblower] assumed an established NP's patient panel, she was scheduled to see 12 patients daily, in addition to unscheduled patients assigned to the patient panel.

In our interview, NP said that during the 2-week orientation period, she took Whistleblower to meet one of Whistleblower alternate collaborative physicians, but the physician was not assigned to see patients in the clinic on that particular day. NP said that she did not recall addressing this issue with Whistleblower again, and did not know whether Whistleblower had ever met any of her assigned collaborative physicians, since this is not an official duty in the orientation process.

Whistleblower shadowed NP until December 15, 2014, when NP was transferred to the GI clinic, after which Whistleblower took over NP panel of patients in the PC Green Clinic.

VA reviewed Whistleblower December 22, 2014, patient appointment scheduling template, noting that it was NP former template; we found that she had 12 scheduled patients and 3 walk-ins. NP said during her interview that a workload of 12 scheduled patients was too heavy for a newly assigned provider, especially since it takes time to learn CPRS, and given the complexity of PC patients. We found no evidence that Whistleblower PC orientation was completed after NP reassignment. The ACoS signed her PC Orientation Checklist, but each item on it was dated November 3, 2014, which date precedes Whistleblower clinical activities.

## FPPE/OPPE

In February 2015, approximately 3 months after hiring Whistleblower, the ACoS completed the NP's initial FPPE as required by VHA Directive 1100.19, *Credentialing and Privileging*, and VHA Directive 2010-025, *Peer Review for Quality Management*.<sup>4</sup> The FPPE covered the period from November 17, 2014, through February 17, 2015 – the time period during which Whistleblower was seeing patients – and identified inadequate documentation in the electronic health record (EHR), poor management of her patients' medical diagnoses, including poor control of chronic medical illnesses, and a poor overall performance evaluation. On March 20, the Nurse Professional Standards Board met to review Whistleblower performance, and recommended her removal from clinical duties pending a complete review of the results of the FPPE.

On March 30, the Medical Center removed the NP from clinical duties pending an unprotected clinical management review of additional medical records. This clinical review reported the same concerns identified previously – inadequate documentation in

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<sup>4</sup> An FPPE or OPPE are considered Management Reviews. They are not protected by 38 U.S.C. § 5705. OPPE is the ongoing monitoring of privileged practitioners and providers to confirm the quality of care delivered and ensure patient safety. FPPE refers to an evaluation of privilege-specific competence of a practitioner or provider who does not have current documented evidence of competently performing requested privileges. FPPE occurs at the time of initial appointment and prior to granting new or additional privileges. FPPE may also be used when a question arises regarding a currently privileged practitioner or provider's ability to provide safe, high-quality patient care. Activities such as direct observation, clinical discussions, and clinical pertinence reviews, if documented, can be incorporated into this process. Information and data considered must be practitioner or provider specific, and could become part of the practitioner's provider profile analyzed in the facility's on-going monitoring. VHA Directive 2010-025, *Peer Review For Quality Management*, June 3, 2010.

the EHR and poor management of medical diagnoses – so she was placed on excused administrative absence from [Redacted] 2015, her effective date of separation. [Redacted] practiced independently during her time of employment at the Medical Center; despite the restrictions of her APRN license. Had there been a consistent collaborative physician involved her provision of care to Veterans, these deficiencies in patient care might have been identified earlier.

We reviewed 30 of the Medical Center's FPPEs and OPPEs on multiple providers to assess the types of items included in the evaluations, and noted that each provider is monitored against the same criteria regardless of their individual area of practice. In addition, when we reviewed [Redacted] FPPE, we found that another provider's name had been entered on her FPPE template, an indication of "cut-and-paste" or other improper documentation.

### Conclusions for Allegation 1

- VA substantiated that [Redacted] assigned collaborative physician did not work with her during her employment at the Medical Center. The purpose of collaboration is to monitor the NP's clinical practice through both direct supervision in the case of real-time consultation, and indirect supervision through retrospective medical record reviews. Additional review is provided through the on-going monitoring of clinical practice under the FPPE/OPPE processes to confirm the quality of care delivered. Although a primary collaborative physician and five alternates were assigned to [Redacted] on paper, her primary collaborative physician was not notified or aware of her assignment. [Redacted] had no contact with her primary collaborative physician until May 26, 2015, after she had been removed from clinical duties.
- VA concluded that [Redacted] violated Mississippi Nursing Practice Law, Miss. Code Ann. 73-15-20(f), and the Board of Nursing's regulations in 30 Miss. Admin. Code Part 2840, Chapter 2, Rule 2.3.C.3). Practice Requirements, by failing to ensure that her clinical practice was appropriately monitored by her physician collaborators in accordance with her state licensure requirements. [Redacted] is responsible for complying with applicable licensure requirements.
- VA concluded that the Medical Center assigned a primary collaborating physician to oversee [Redacted] clinical practice but failed to ensure that the primary collaborating physician was aware of the assignment and appropriately monitored [Redacted] clinical practice, in accordance with her state licensure requirements.
- VA concluded that another NP's name entered on [Redacted] FPPE was an indication of poor administrative oversight, and might raise questions about the accuracy of the information.
- VA concluded that the Medical Center failed to provide [Redacted] with an adequate orientation.

## Recommendations to the Medical Center

1. Determine who was responsible for the improper monitoring of **Whistleblower** practice, and take appropriate educational, administrative, and/or disciplinary action.
2. Establish clear written procedures to ensure that all newly assigned NPs are introduced to their collaborative physicians, and that assigned collaborative physicians establish working relationships with the NPs assigned to them.
3. Review the current system of documenting the monitoring of NPs who are not LIPs, and make changes as needed to ensure appropriate monitoring.
4. Review the Medical Center's compliance with VHA Directive 2010-025, *Peer Review for Quality Management*. Review the Medical Center's FPPE/OPPE processes to ensure compliance with VHA policy.
5. Ensure that all newly assigned PC providers receive a complete, step-by-step orientation, allowing sufficient time to learn the CPRS and to become familiar with the collaboration process.

## Allegation 2

**The Director, CoS and ACoS, PC have not ensured that collaborative physicians are appropriately monitoring each nurse practitioner's (NP) practice, despite the VA's prior assurances that the Jackson VAMC is in compliance with state collaboration requirements.**

## Findings

We interviewed all PC providers on duty, including NPs and physicians, as well as NPs from clinical specialty areas of the Medical Center. All of them except **Whistleblower** said that they collaborated with physicians at the Medical Center in a formal or informal manner during their daily practice. All NPs who hold Mississippi licenses described an ongoing relationship with their collaborating physicians. When we reviewed each Scope of Practice, credentials file, and other documentation, we found that each NP (other than **Whistleblower**) had been appropriately assigned a collaborative physician and that each was actively engaged in the collaborative process.

## Conclusions for Allegation 2

- **VA did not substantiate** that the Medical Center leadership failed to ensure that collaborative physicians are appropriately monitoring each NP's practice, other than that of the whistleblower. The purpose of collaboration is to monitor the NP's clinical practice through both direct supervision in the case of real-time consultation, and indirect supervision through retrospective medical record reviews. Additional review is provided through the on-going monitoring of clinical practice under the FPPE/OPPE processes to confirm the quality of care delivered.

- All other NPs employed at the Medical Center established formal agreements with collaborative physicians, and their practices are appropriately monitored by their assigned collaborative physician and by the appropriate clinical leader, such as the ACoS, PC.

### **Recommendation to the Medical Center**

None.

### **Allegation 3**

The Director, CoS and ACoS, PC, and [Whistleblower] collaborative physicians caused a substantial and specific danger to public health or safety by failing to ensure that collaborative physicians are appropriately monitoring each NP's practice.

### **Findings**

VA found that there was a potential danger to public health and safety by not appropriately monitoring [Whistleblower] practice. The clinical management review of her practice identified inadequate documentation in the EHR as well as poor management of her patients' medical diagnoses, including poor control of chronic medical illnesses. The Deputy ACoS, PC, has reviewed and is monitoring all of [Whistleblower] patients. Assigned collaborative physicians and the Deputy ACoS, PC are monitoring the practice of all NPs required to have a collaborative physician at the Medical Center.

### **Conclusions for Allegation 3**

- VA partially **substantiated** this allegation. We determined that although the Medical Center management is ensuring that collaborative physicians are appropriately meeting the Mississippi state requirements for collaboration and are currently following the local and VHA policies and directives for collaboration, it did not do so for [Whistleblower]

### **Recommendation to the Medical Center**

See Recommendation 1.

## Attachment A

Documents in addition to Veterans EHRs reviewed:

VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014.

VHA Handbook 1101.02, *Primary Care Management Module (PCMM)*, April 21, 2009.

VHA Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports*, December 28, 2009.

VHA Handbook 1100.18, *Reporting and Responding To State Licensing Boards*, December 22, 2005.

VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

VHA Handbook 1004.08, *Disclosure Of Adverse Events To Patients*, October 2, 2012.

VHA Handbook 1907.01, *Health Information Management And Health Records*, March 19, 2015.

VHA Handbook 5005/27 Part II Appendix G6, *Collaboration Relationships for Nurse II and Nurse III*, March 17, 2009.

VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.

VHA Communication of Test Results Toolkit, May 30, 2012, updated July 11, 2013.

Mississippi Board of Nursing, *Nursing Practice Law*, July 1, 2010, [www.msbn.state.ms.us](http://www.msbn.state.ms.us).

Medical Center Policy Number: K-11P-60, *Credentialing and Privileging of Independent Practitioners*, December 31, 2012.

Medical Center Policy Number: F-11Q-48, *Medical Staff Focused Professional Practice Evaluations and Ongoing Professional Practice Evaluations (FPPE/OPPE)*, January 22, 2014.

Medical Center Policy Number: A-11Q-41, *Peer Review for Quality Management*, May 28, 2014.

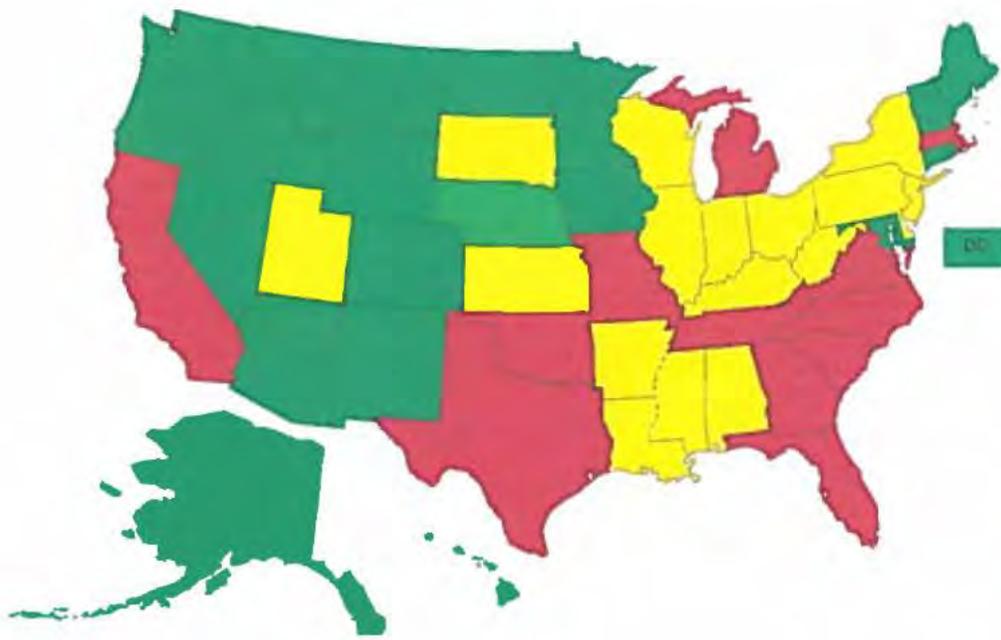
Medical Center Primary Care Service Organizational Chart, February 4, 2015.

Medical Center Primary Care Staffing Phone Tree, May 2015.

## Attachment B

In 21 states and the District of Columbia, NPs practice without any requirement for collaboration with, or supervision by, a physician.

### 2015 Nurse Practitioner State Practice Environment



#### Full Practice

State practice and licensure law provides for all nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribing medications—under the exclusive licensure authority of the state board of nursing. This is the model recommended by the Institute of Medicine and National Council of State Boards of Nursing.

#### Reduced Practice

State practice and licensure law reduces the ability of nurse practitioners to engage in at least one element of NP practice. State requires a regulated collaborative agreement with an outside health discipline in order for the NP to provide patient care.

#### Restricted Practice

State practice and licensure law restricts the ability of a nurse practitioner to engage in at least one element of NP practice. State requires supervision, delegation, or team-management by an outside health discipline in order for the NP to provide patient care.

