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

The Special Counsel

February 18, 2016

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

Re: OSC File No. DI-15-3037

Dear Mr. President:

Pursuant to my duties as Special Counsel, I have enclosed an unredacted Department of Veterans Affairs' (VA) report based on disclosures of wrongdoing at the G.V. (Sonny) Montgomery VA Medical Center (Jackson VAMC), Jackson, Mississippi, made to the Office of Special Counsel (OSC). Joanna Lousteau, a nurse practitioner, alleged that during her employment at the Jackson VAMC, from November 17, 2014, to March 20, 2015, she was not appropriately supervised and did not have a relationship with any collaborative physician as required by state regulations and agency policy. I have reviewed the VA's report and, in accordance with 5 U.S.C. § 1213(e), provide the following summary of the agency investigation and whistleblower comments as well as my findings.[1]

Ms. Lousteau's allegations were referred to Secretary Robert McDonald for investigation pursuant to 5 U.S.C. § 1213(c) and (d). Secretary McDonald forwarded the allegations to the Interim Under Secretary for Health, who directed the Office of the Medical Inspector to conduct the investigation. Secretary McDonald delegated responsibility to submit the agency's report to then-Chief of Staff Robert L. Nabors, II, who submitted the report to OSC on October 28, 2015.

The agency substantiated Ms. Lousteau's allegation that Dr. Vera Brooks, her assigned collaborating physician, did not actively monitor Ms. Lousteau's work as

[1]The Office of Special Counsel (OSC) is authorized by law to receive disclosure of information from federal employees alleging violation 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 the aforementioned conditions exists, she is required to advise the appropriate agency head of her determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c) and (g). 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).

required by Mississippi Nursing Practice Law, creating the potential for a danger to public health and safety. The investigation found that a primary collaborative physician and five alternate physicians were assigned to supervise Ms. Lousteau, but that Dr. Brooks was never notified of the assignment. The investigation also confirmed that Ms. Lousteau's Focused Professional Practice Evaluation (FPPE) erroneously contained the name of another nurse practitioner, indicating poor administrative oversight on the part of the facility. The agency further concluded that facility management failed to provide Ms. Lousteau with adequate orientation.

As a result of these findings, the VA made five recommendations to the facility to improve its oversight of nurse practitioners. These recommendations include:

(1) determine responsibility for the failure to ensure that the whistleblower's clinical practice was properly monitored and take appropriate disciplinary or other action as required;

(2) establish written procedures to ensure that all new nurse practitioners are introduced to their collaborating physicians and that working relationships are established;

(3) review the facility's system for documenting nurse practitioner monitoring and make changes as needed;

(4) review the facility's compliance with VHA Directive 2010-025 peer reviews; and,

(5) ensure all new primary care providers receive a complete orientation.

On January 21, 2016, the VA reported that the Jackson VAMC has completed all of the recommendations above with the exception of recommendation (3), which is ongoing. The VA explained that, regarding recommendation (3), the facility reviewed its processes and implemented a monthly reporting requirement to the Clinical Executive Board to document continued monitoring of nurse practitioners. The VA also reported that in response to recommendation (1), the associate chief of staff of Primary Care was found to be responsible for nurse practitioner oversight, and received a verbal counseling from the facility chief of staff on expected oversight responsibilities. Facility leadership also appointed an acting deputy chief to assist the associate chief of staff of Primary Care with nurse practitioner supervision and administrative support.

In her comments on the agency's report, Ms. Lousteau stated that Dr. Brooks never signed her Scope of Practice document as required. Ms. Lousteau also confirmed that her FPPE paperwork was not properly completed, was improperly signed by Dr. Brooks, and falsely stated that Ms. Lousteau was unavailable to sign it herself.

Ms. Lousteau noted that the FPPE paperwork as completed violated facility and agency policies.

I have reviewed the original disclosures, the agency report, and the whistleblower's comments. Based upon my review, I have determined that the VA's report contains all of the information required by statute and the findings appear reasonable. I thank Ms. Lousteau for bringing these concerns to my attention, particularly in light of the facility's previous failure to properly supervise and monitor nurse practitioners in accordance with state law. *See* OSC File No. DI-12-3816.[2] I note that Ms. Lousteau made several important points regarding both general oversight of nurse practitioners at the Jackson VAMC and her personal experience at the facility. In this instance, however, it appears that the VA took appropriate corrective and administrative actions in response to the allegations that were substantiated.

As required by 5 U.S.C. §1213(e)(3), I am now transmitting the unredacted agency report and Ms. Lousteau's comments to you and 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 the whistleblower's comments in OSC's public file, which is available online at www.osc.gov.[3] This matter is now closed.

Respectfully,

Carolyn N. Lerner

Enclosures

---

[2]OSC File No. DI-12-3816 included an allegation that nurse practitioners in Primary Care at the Jackson VAMC were practicing with little to no required supervision and that no internal chart reviews were being conducted as required by state licensing law. The VA's report in that matter substantiated these allegations, finding that the facility was in violation of state law on the issue of collaborating agreements. The VA recommended that the facility immediately ensure that all nurse practitioners who were required to have collaborative agreements have approved agreements put in place. The VA also recommended that the Jackson VAMC implement a process to monitor nurse practitioner collaboration and documentation. The VA subsequently confirmed to OSC that the facility was appropriately monitoring nurse practitioners with 100% compliance.

[3]The VA provided OSC with a report containing employee names (enclosed), and a redacted report in which employees' names were removed. The VA did not provide a basis for the redactions; however, the VA generally cites Exemption 6 of the Freedom of Information Act (FOIA) (5 U.S.C. § 552(b)(6)) as the basis for its redactions to the report produced in response to 5 U.S.C. § 1213, and requests that OSC post the redacted version of the report 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 as an accommodation.