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The Special Counsel

March 15, 2016

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

Re: OSC File No. DI-13-2644

Dear Mr. President:

Pursuant to my duties as Special Counsel, I am forwarding an agency report based on disclosures made by an employee of the Department of Veterans Affairs (VA), G.V. Montgomery VA Medical Center (Jackson VAMC or facility) Jackson, Mississippi, alleging that employees engaged in conduct that constituted violations of law, rule, or regulation; gross mismanagement; an abuse of authority; and a substantial and specific danger to public health. The whistleblower, who is anonymous, alleged that the Jackson VAMC is not carrying out physician credentialing and privileging in accordance with agency-wide and VAMC local policies. 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]

The VA substantiated the whistleblower's allegations that the Jackson VAMC did not comply with agency-wide and local policies governing credentialing and privileging. The agency also concluded that the facility did not provide the Clinical Executive Board (CEB) with information sufficient for it to make an informed decision on credentialing and privileging, and that CEB votes on credentialing and privileging were inaccurately recorded in the Professional Standards Board (PSB) minutes. Although the Office of the Medical Inspector (OMI) found insufficient evidence to conclude that these improper practices may have resulted in incorrect privileging of providers, it nevertheless recommended

[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).

that the facility revise its credentialing and privileging process to ensure consistency and compliance with the governing policies. Based on my review, I have determined that the agency reports contain the statutorily required information. However, the VA's findings do not appear reasonable given the agency's apparent lack of progress in implementing these corrective actions, as well as the whistleblower's ongoing concern that providers continue to be improperly privileged.

The whistleblower's allegations were referred to then-Secretary Eric K. Shinseki to conduct an investigation pursuant to 5 U.S.C. § 1213(c) and (d). Secretary Shinseki delegated the authority to sign and transmit the VA's report to then-Chief of Staff Jose D. Riojas. On August 13, 2013, Mr. Riojas submitted the agency's report to OSC based on an investigation conducted by OMI. The agency submitted a supplemental report to OSC on May 27, 2014, and provided an update on July 14, 2015. Pursuant to 5 U.S.C. § 1213(e)(1), the whistleblower provided comments on the agency's findings.

I. The Whistleblower's Disclosures

The whistleblower disclosed that the Jackson VAMC employed credentialing and privileging in violation of *Veterans Health Administration (VHA) Handbook 1100.19* (November 14, 2008), which sets agency-wide policies governing credentialing and privileging of VA providers. Credentialing ensures that providers meet the technical requirements for their position, while privileging determines whether a provider may deliver care based on his or her licensure and clinical competence and the facility's capabilities. The VHA Handbook and local policy require that service chiefs conduct an initial review of credentialing and privileging applications and make recommendations to the credentialing and medical staff executive committees. At the Jackson VAMC, the credentialing committee is the PSB, while the medical staff executive committee is the CEB. According to the Jackson VAMC's bylaws, the PSB first reviews the applications and supporting documents, including information such as education, licensure, and malpractice claims. Upon completion, the PSB forwards the application to the CEB for approval and additional questions. The facility director then conducts a final review of the application.

According to the whistleblower, the PSB has consistently failed to provide sufficient information to the CEB to make appropriate determinations on provider applications. Specifically, the whistleblower alleged that information including applicant names, malpractice history, and disciplinary history is not being provided to the CEB. The whistleblower asserted that this problem was exacerbated by the introduction of email voting for the CEB on certain applications. In addition, the whistleblower disclosed that CEB votes on credentialing and privileging were regularly and falsely reported in the Jackson VAMC's PSB meeting minutes as having been taken. In support of the allegations that these were systemic failures, the whistleblower provided two examples of

practitioners who were not privileged according to agency-wide and local policies. According to the whistleblower additional practitioners may have been similarly affected.

II. The Agency Reports

The report concluded that the Jackson VAMC was not compliant with the VHA Handbook, agency policy, and facility bylaws because the director approved privileging and re-privileging requests before receiving the CEB's recommendation. The report also substantiated that the facility was not providing sufficient information to the CEB for it to make an informed recommendation about applicants' requests for credentials and privileges. The report also indicated that the CEB's voting members did not have access to the PSB's minutes, including information about each applicant that the PSB discussed. Specifically, the report found that in some instances provider names were not included, while in others, names were included but with only limited supporting information.

Significantly, the report found that in all instances, the director made a determination without considering information from the committees charged with recommending whether to grant or deny an application. According to the report, in January 2013, the facility instituted electronic voting for CEB members to consider and approve the PSB's recommendations. Prior to January 2013, PSB minutes submitted to the director falsely reported that CEB voting had already taken place. Although reflected in the PSB minutes, the investigation failed to reveal evidence that CEB voting actually occurred. In support of the allegations concerning the re-privileging of the two practitioners, the report substantiated oversight mismanagement, misstatement of facts, and that the CEB was not involved in either determination.

Despite these findings, the investigation did not substantiate that these practices may have resulted in the incorrect privileging of additional providers, because there was no evidence of intentional misconduct and there was some monitoring of the process, albeit inconsistent with agency policy. The report did not state why these findings do not demonstrate systemic non-compliance. Consequently, the report recommended that the Jackson VAMC revise its credentialing and privileging process so that it is compliant with agency-wide and local policies, and ensures that the appropriate bodies have equal access to the information required prior to the director's approval. If retained in the privileging process, the report recommended a review of the utilization and effectiveness of the electronic voting system. Finally, the report recommended that the facility director date any privileging documents that he is required to sign.

On May 12, 2014, the agency responded to OSC's request for an update on the status of these recommendations. At that time, the facility's revision of its credentialing and privileging process was ongoing. According to the supplemental report, the Jackson VAMC no longer uses electronic voting. Further, the report found that as of September 5, 2013, the VAMC director began dating and signing documents in order to confirm the

sequencing of the credentialing and privileging process. The Jackson VAMC did not take any disciplinary action against any of the individuals who knowingly engaged in improper processes discussed throughout the report. A July 14, 2015 status report indicated that the facility's updated bylaws were approved and signed in October 2013. The updated bylaws require that the CEB receive a copy of the PSB's agenda prior to meeting, including names of applicants and a review of the applicants' practice evaluation files.

III. The Whistleblower's Comments

The whistleblower indicated that other than the clerical fixes related to dating documents and electronic voting, little has been done to change the deliberate circumvention of the agency credentialing and privileging process. While there is an effort to provide more information to enable the facility to make informed decisions regarding applicants, the whistleblower stated that there has not been a formal revision of the agency policy, as recommended in the report almost two years ago. Thus, the whistleblower confirmed that the agency continues to be non-compliant with VA policies, including Handbook 1100.19. Specifically concerning the Jackson VAMC's update that the policy revision is "ongoing," the whistleblower characterized the process more appropriately as "stalled."

The whistleblower informed OSC that as recently as November 2015, the ophthalmologist identified in the report was re-privileged by the CEB even though the provider had not been in clinical practice since April 2015. The provider allowed his privileges to lapse in November 2014. The whistleblower explained that the PSB initially reviewed the provider's privileges as a new hire and voted not to re-privilege the provider. Director of VHA Credentialing and Privileging Kathryn Enchelmayer then convened a second PSB for the provider, which treated his application as a renewal instead of a new hire. This effectively prevented the PSB from reviewing his cumulative professional record and resulted in a vote to re-privilege. The whistleblower questioned the propriety of this second PSB.

The whistleblower also reiterated that none of the individuals involved with the wrongdoing discussed in the agency's report was appropriately held accountable. The whistleblower stated that the ophthalmologist discussed in the report has undergone only administrative suspensions so that the facility can avoid reporting the provider's wrongdoing to the National Practitioner's Databank (NPDB). The whistleblower explained that this deliberate conduct ignores the facility's legal and ethical responsibility to report unqualified providers to state licensing boards so that these independent bodies can make their determinations according to state law. Further, the whistleblower explained that while this provider is on an indefinite administrative suspension, he continues to collect a full salary and accrue all related benefits. The whistleblower also maintains that Ms. Enchelmayer's participation in the OMI investigation was

inappropriate and created a conflict of interest. The whistleblower explained that Ms. Enchelmayer's position allowed her to knowingly and improperly advise the administration before OMI's investigation in an effort to whitewash the facility's wrongdoing. Thus, the whistleblower noted a continued conscious manipulation of the credentialing and privileging process affecting the Jackson VAMC's ability to ensure that individuals receive care by qualified practitioners.

IV. The Special Counsel's Findings

Based on my review, I have determined that although the agency reports contain all of the information required by statute, the findings do not appear reasonable, given the facility's continued noncompliance. The agency's report substantiated that the Jackson VAMC did not follow the proper credentialing and privileging processes required by agency and local policies. Nevertheless, the agency did not provide evidence supporting its contradictory finding that other than the two examples cited by the whistleblower, no other providers were incorrectly privileged. In the absence of such information, it is unreasonable to conclude that no additional practitioners were privileged or credentialed improperly.

The report also concluded that while the Jackson VAMC was "technically noncompliant," evidence of some oversight, even if outside of the process prescribed by policy, demonstrated and intent to comply. A 2008 congressional hearing on negligent credentialing and privileging practices leading to a high rate of patient deaths at another VA facility emphasized that breaches related to patient care are serious.[2] Thus, mere intent to follow policy or anything less than full compliance should not be tolerated. Further, by circumventing the CEB and PSB, the facility undermined the very mechanism put in place to ensure that only qualified applicants are credentialed and receive privileges. This conduct demonstrates deliberate disregard for the facility's ability to provide adequate care.

In addition to the Jackson VAMC's failure to follow its internal procedures to ensure that qualified practitioners provide care, the facility is not reporting negative information about healthcare practitioners to the NPDB or the state medical licensing board as required. Withholding information required by these independent bodies impedes their ability to monitor those to whom licenses are granted, improve healthcare quality, and hold wrongdoers accountable. For these reasons, I find the agency's findings unreasonable. Implementing a credentialing and privileging process according to agency-wide standards is vital to ensure that providers are qualified to perform basic functions at the facility, and to avoid the serious consequences of incompetent or unqualified providers practicing medicine. Accordingly, I recommend that action be taken to fully

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[2] *Credentialing and Privileging: A Patient Safety Issue, Hearing Before the Subcomm. On Oversight and Investigations and Comm. On Veterans Affairs, 110th Cong. 110-65 (1998).*

review the credentialing and privileging of applicants approved prior to the OMI's investigation in order to fully determine whether the facility's failures had systemic consequences. I also urge the agency to reconsider its determination that the facility's failures were unintentional and that, therefore, no employees need to be held accountable.

As required by 5 U.S.C. § 1213(e)(3), I have sent copies of the unredacted reports to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed copies of the redacted reports in our public file, which is available online at www.osc.gov.[3] OSC has now closed this file.

Respectfully,

Carolyn N. Lerner

Enclosures

[3]The VA provided OSC with reports containing employee names (enclosed), and a redacted report in which employees' names were removed on the basis of the Freedom of Information Act (FOIA) (5 U.S.C. § 552(b)(6)). OSC objects to this as a basis for redactions to a report produced in response to 5 U.S.C. § 1213, 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).