



DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

December 1, 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 Nos. DI-14-3209, 4305, 5078

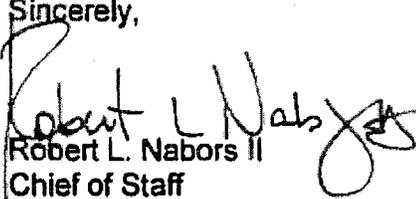
Dear Ms. Lerner:

I am responding to your letter regarding allegations made by whistleblowers at the G.V. (Sonny) Montgomery Department of Veterans Affairs (VA) Medical Center, (hereafter, the Medical Center) located in Jackson, Mississippi. The whistleblowers alleged that the quality of care provided by a primary care Nurse Practitioner (NP) at the Medical Center was inadequate, resulting in a violation of law and policy and creating a substantial and specific danger to public health and safety. 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).

When this referral was received, the Interim Under Secretary for Health was assigned to review this matter and prepare a report in compliance with § 1213(c) and (d). She, in turn, directed the Office of the Medical Inspector to assemble and lead a VA team to conduct an investigation. The report substantiates the first two allegations regarding inadequate care having been provided by an NP and harm to patients resulting from that inadequate care. The report did not substantiate the third and fourth allegations, i.e., that leadership was aware of the NP's deficiencies, but took no action to correct them until the NP left the facility, and that the facility's plan to review the NP's patient charts for quality of care issues would not constitute a thorough review. The report makes 11 recommendations to the Medical Center and 1 to the Veterans Health Administration. We will send your office follow-up information describing actions that have been taken by the Medical Center and other entities to implement these recommendations.

Thank you for the opportunity to respond.

Sincerely,


Robert L. Nabors II
Chief of Staff

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
Washington, DC

Report to the
Office of Special Counsel
OSC File Numbers DI-14-3209, 4305, 5078

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



Report Date: November 17, 2015

TRIM 2015-D-1973

Executive Summary

The then Interim Under Secretary for Health (I/USH) requested that the Office of the Medical Inspector (OMI) assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the G.V. Sonny Montgomery VA Medical Center (hereafter, the Medical Center) located in Jackson, Mississippi. [Employee 1 (B6)], Medical Support Assistant (MSA), a former employee in the primary care clinic (PCC), [Employee 2 (B6)], Compensation and Pension Clinic, and an anonymous whistleblower made allegations about the quality of care provided by a primary care (PC) Nurse Practitioner (NP) at the Medical Center, and that employees are engaging in conduct that may constitute violations of laws, rules or regulations, gross mismanagement, and/or conduct which may lead to a substantial and specific danger to public health and safety. [Employee 1 (B6)] and [Employee 2 (B6)] both consented to the release of their names. VA conducted a site visit to the Medical Center on May 18–21, 2015.

Specific Allegations of the Whistleblowers:

1. An NP in the Primary Care Clinic regularly failed to provide sufficient care to patients.
2. As a result of this failure to provide adequate care, patient health was placed in jeopardy.
3. Management was aware of these deficiencies for several years, but took no action to correct them until the nurse practitioner left the facility.
4. The current plan to address the nurse practitioner's patient charts does not constitute a thorough review of potential harm to patients and places patients at further risk for substandard care.

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 an NP in the PCC regularly failed to provide sufficient care to patients. When this provider's care was identified in March 2014 as being below the standard of care, the Associate Chief of Staff (ACoS), PC, and Chief of Staff (CoS) immediately ordered a 90-day unprotected clinical review. After reviewing the results of the clinical review on June 19, 2014, Medical Center officials summarily suspended the NP's privileges, pending comprehensive review and due process. On June 30, 2014, the NP submitted a letter of resignation, effective [NP (B6)] 2014,

thereby surrendering his privileges while under investigation for possible professional incompetence, improper professional conduct or substandard care, with the threat of revocation of [REDACTED] clinical privileges after their summary suspension.

- During the Deputy Under Secretary for Health for Operations and Management (DUSHOM) investigation in fiscal year (FY) 2013 for OSC File No. DI-12-3816, VA found that, contrary to state law, this NP had practiced at the Medical Center without a collaborator while working under [REDACTED] Mississippi license.
- While employed at the Medical Center, this NP engaged in conduct that constituted violations of Mississippi laws, which led to a substantial and specific danger to public health and safety.
- Prior to the FY 2013 DUSHOM investigation, the current ACoS, PC and CoS were not in leadership positions at the Medical Center. When deficiencies in the NP's clinical practice were identified in the 90-day unprotected clinical review completed in June 2014, the current clinical leadership acted upon them. The former clinical leadership is no longer employed within VA. Following the NP's resignation and voluntary surrender of privileges on [REDACTED] NP (b6) 2014, the facility initiated a clinical review on July 29, 2014, of the care provided by the NP to each of [REDACTED] NP (b6) patients. The Veterans Health Administration (VHA) Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, requires the initiation of a review of an individual's clinical practice within 7 calendar days of when a licensed practitioner leaves VA employment or information is received that suggests the clinical practice of a current licensed practitioner has met the reporting standard to determine if there may be substantial evidence that the individual so substantially failed to meet generally-accepted standards of clinical practice as to raise reasonable concern for the safety of patients.
- Following the May 2015 VA site visit, the ACoS, PC and CoS initiated mandatory procedures to report the NP to the State Licensing Board (SLB), in accordance with the VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*; however, these procedures were not initiated immediately.
- Accountability actions are warranted regarding the delay in initiating the clinical review and beginning the process to report the NP to the SLB.

Recommendations to the Medical Center

1. Complete the mandatory procedures to report the NP to the SLB, in accordance with the VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*.
2. Offer the NP a "limited fair hearing" notice to determine whether [REDACTED] NP (b6) knew [REDACTED] NP (b6) was under investigation for substandard care, professional misconduct, or professional incompetence when [REDACTED] NP (b6) resigned and surrendered [REDACTED] NP (b6) clinical privileges.

3. Ensure that all advanced practice registered nurses (APRN) are working in accordance with the rules and regulations of their state licensure, and take appropriate corrective actions as indicated.

Recommendation to VHA

4. Determine leadership accountability for the delays in initiating the clinical review and beginning the process to report the NP to the SLB, in accordance with VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*.

Conclusions for Allegation 2

- VA substantiated that as a result of the NP's failure to provide adequate care, patient health was placed in jeopardy. Specifically, two Veterans experienced delays in diagnosis of advanced cancer while other patients experienced adverse events as a result of the NP's failure to properly manage their chronic conditions or respond to abnormal test results. The Deputy ACoS, PC is currently monitoring patients where clinical concerns were identified.
- The Medical Center completed Institutional Disclosures on May 14 and 15, 2015, with the two Veterans who experienced delays in cancer diagnosis.

Recommendations to the Medical Center

5. Conduct external peer reviews of all of the NP's patients who experienced adverse events, and take appropriate action as defined in VHA Handbook 1004.08, *Disclosure of Adverse Events to Patients*.
6. Continue to monitor patients found to have quality of care concerns, specifically those on the Deputy ACoS, PC's patient list, and provide appropriate follow up care as needed.
7. Consider providing remote access to electronic health records (EHR) for all PC providers in order to allow them to complete clinical work while away from the Medical Center.

Conclusions for Allegation 3

- VA did not substantiate that Management was aware of these deficiencies for several years, but took no action to correct them until the NP left the facility. We found evidence that the deficiencies were first identified and acted upon by the current Medical Center's clinical management, including the ACoS, PC and CoS. The Medical Center Director heeded their concerns and took appropriate administrative action in 2014 when these issues were identified. As a result, no additional accountability actions are warranted.

- We reviewed this NP's personnel record and credentialing and privileging file, examined other documentation, conducted interviews, and found no evidence that the current management was aware of the deficiencies prior to receiving the results of the December 2013 Veterans Integrated Service Network (VISN) 16 protected peer review in February 2014.
- VA found that the ongoing professional practice evaluation (OPPE) was not initiated in a timely manner, since this NP was hired in [REDACTED], and the first OPPE was not completed until 2011. VA also found that current OPPEs were not completed in accordance with VHA Directive 2010-025. Accountability actions are warranted since clinical leadership is responsible for ensuring the timely, thorough completion of OPPEs.
- VA found no evidence that current PC leadership was aware of this NP's extensive use of cut-and-paste notes, templates, and lack of follow up on clinical alerts or patient issues until the VISN's external clinical review and the Medical Center's subsequent focused professional practice evaluations (FPPE) were completed.
- When clinical concerns were noticed by some MSAs and nursing staff members, they did not bring their concerns to the attention of their respective administrative and nursing clinical managers.

Recommendations to the Medical Center

8. The CoS should continue to review the Medical Center's FPPE and OPPE processes and take actions to ensure that they are completed timely by the ACoS, PC, and that there is variation in the content based upon clinical area.
9. Provide education to ensure a culture that encourages a willingness to report concerns to management and leadership.

Conclusions for Allegation 4

- VA did not substantiate that the current plan to address the NP's patient charts is inadequate, and therefore, does not place patients at further risk for substandard care.
- VA found that several PC providers are confused about the difference between FPPEs, OPPEs, peer reviews, and clinical reviews.

Recommendations to the Medical Center

10. Review quality management (QM) policies and:
 - Reeducate all applicable, clinical staff on the difference between the FPPE, OPPE, and peer review processes, with emphasis on the non-punitive nature of peer review for QM purposes.

- o Use peer review to assess routine care, not just in cases where adverse events or unanticipated outcomes have occurred.
 - o Ensure that peer review for QM is not used as a proxy for a clinical review, which carries the potential for negative administrative consequences for the provider being reviewed.
11. Request a consultative visit from the Office of Quality Safety and Value pertaining to the Medical Center's compliance with VHA Directive 2010-025, *Peer Review for Quality Management*. Review the Medical Center's FPPE and OPPE processes to ensure compliance with VHA policy in VHA Directive 2010-025 and VHA Handbook 1100.19, *Credentialing and Privileging*.
 12. Provide protected administrative time for NPs as well as all PC providers in accordance with VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook*.

Summary Statement

OMI has developed this report in consultation with other 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 from a Human Resources (HR) perspective to establish accountability, when appropriate, for improper personnel practices. VA found violations of VA and VHA policy, and notes that while the NP was employed at the Medical Center there had been a substantial and specific danger to public health and safety. The NP resigned in 2014.

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I. Introduction

The then I/USH requested that OMI assemble and lead a VA team to investigate allegations lodged with OSC concerning the G.V. Sonny Montgomery VA Medical Center (hereafter, the Medical Center) located in Jackson, Mississippi. [REDACTED] MSA, a former employee in the primary care clinic PCC, [REDACTED] Employee 2 (B6), Compensation and Pension Clinic, and an anonymous whistleblower made allegations about the quality of care provided by a PC NP at the Medical Center, and that employees are engaging in conduct that may constitute violations of laws, rules or regulations, gross mismanagement, and/or conduct which may lead to a substantial and specific danger to public health and safety. [REDACTED] Employee 1 (B6) and Employee 2 (B6) both consented to the release of their names. VA conducted a site visit to the Medical Center on May 18-21, 2015.

II. Facility Profile

Part of 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 posttraumatic 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 PC Service consists of the 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. The PCC has five patient care aligned teams (PACT); Green, Blue, Silver, Purple, and Pink.

III. Specific Allegations of the Whistleblowers

1. A nurse practitioner in the Primary Care Clinic regularly failed to provide sufficient care to patients.
2. As a result of this failure to provide adequate care, patient health was placed in jeopardy.
3. Management was aware of these deficiencies for several years, but took no action to correct them until the nurse practitioner left the facility.

4. The current plan to address the nurse practitioner's patient charts does not constitute a thorough review of potential harm to patients and places patients at further risk for substandard care.

IV. Conduct of Investigation

The VA team conducting the investigation consisted of (b6) Medical Investigator (an internist) and (b6), Clinical Program Manager, both of the OMI; (b6) Liaison for National APRN Policy, VHA Office of Nursing Service; (b6), Clinical Quality Specialist, Office of Quality Safety and Value; and (b6) Supervisory HR Specialist, Veterans Benefit Administration. VA also consulted (b6), Director, Medical Staff Affairs (Credentialing & Privileging). The team reviewed relevant policies, procedures, professional standards, reports, memoranda, and other documents listed in Attachment A. We toured the Medical Center's PCC and held entrance and exit briefings with Medical Center leadership.

VA interviewed (b6) Associate CoS, PC (ACoS, PC), by teleconference on May 5, with a follow-up interview on June 3, 2015. We interviewed Employee 1 (B6) via teleconference on May 7, 2015; he has been working at the Jesse Brown VA Medical Center, Chicago, since October 6, 2014. Employee 2 (B6) was offered a telephone, as well as a face-to-face interview at the Medical Center, but declined the telephone interview, opting instead for a face-to-face on-site interview on May 18. Both whistleblowers provided names of employees they wanted interviewed and we interviewed all of them. The following employees attended the Entrance Briefing:

- (b6) CoS
- (b6) Assistant Director
- (b6), Acting Associate Director
- (b6), Associate Director Patient Care Services (ADPCS)
- (b6), Chief, QM
- (b6) Assistant Chief, QM

We interviewed these Medical Center employees:

- (b6) Medical Center Director
- (b6) MD, CoS
- (b6), MD, ACoS, PC
- (b6), MD, Deputy ACoS, PC
- (b6), MD, PC Purple Clinic
- (b6) MD, PC Blue Clinic
- (b6) MD, PC Blue Clinic
- (b6), MD, PC Pink Clinic
- (b6), MD, PC Green Clinic
- (b6) NP, Compensation and Pension Clinic

- (b6), NP, (former NP, PC Purple Clinic)
- (b6), NP, PC Green Clinic
- (b6), NP, PC Blue Clinic
- (b6), NP, PC Green Clinic
- (b6), RN, Nursing Supervisor, PC
- (b6), RN, PC Purple Clinic (former Blue Clinic)
- (b6), RN, PC Blue Clinic
- (b6), RN, PC Blue Clinic
- (b6), RN, PC Green Clinic
- (b6), licensed practical nurse (LPN), PC Purple Clinic
- (b6), LPN, PC Blue Clinic
- (b6), MSA Supervisor
- (b6), MSA PC Blue Clinic
- (b6), Peer Support Specialist

The following employees attended the Exit Briefing:

- (b6) Medical Center Director
- (b6), MD, CoS
- (b6) ADPCS
- (b6), Acting Associate Director
- (b6), Acting Assistant Director
- (b6), Chief, QM
- (b6), Assistant Chief, QM
- (b6), Acting AA to Medical Center Director
- (b6), Executive Assistant to Associate Director

V. Findings, Conclusions, and Recommendations

Background

In 2013, as part of a complaint filed with OSC, **Employee 2 (B6)** made allegations about inadequate physician staffing, the failure to properly supervise NPs, and other PC concerns at the Medical Center. These allegations, amongst others, were substantiated by a team of subject matter experts sent by the DUSHOM, who conducted site visits to the Medical Center on April 15–19, and May 7–8, 2013, and issued two reports to OSC in June 2013: DI-12-3816 and DI-13-1713. OMI conducted a follow-up site visit to the Medical Center on October 22–23, 2013, to oversee implementation of the DUSHOM team's recommendations and the Medical Center's action plan. One recommendation was, "the Medical Center should conduct a clinical quality of care review, [also known as a clinical review, which is a type of management review] of a representative sample of the patient EHR for all NPs, as well as all physicians, who worked in Primary

Care...."¹ The VISN and the Medical Center established that they would review 30 EHRs, along with OPPE data, to review the quality of care provided by each PC physician and NP. Additionally, if issues were identified during the review, an unprotected clinical review would be conducted. The VISN 16 clinical review, which was a peer review for QM, was protected under 38 U.S.C. § 5705.

VISN 16 leadership oversaw the completion of an external, protected peer review for QM on each of the PC providers at the Medical Center totaling 2,010 cases. Protected peer reviews were completed in December 2013. Unprotected clinical reviews were later conducted, and the relevant details are discussed below.

Allegation 1

An [NP] in the Primary Care Clinic regularly failed to provide sufficient care to patients.

Quality of Care Issues

In December 2013, the ACoS, PC received her appointment to this position.² Prior to that time, all ACoS, PC duties were completed by multiple VHA physicians from other facilities in acting roles. One of the ACoS, PC's first assigned tasks was to conduct an unprotected clinical review of the medical care provided by a primary care provider, NP (b6) who was employed by the Medical Center from NP (b6) to NP (b6) 2014. On March 11, 2014, the Professional Standards Board (PSB) recommended a 90-day unprotected clinical review of 60 additional EHRs, which was completed the first week of June 2014.³ A total of 30 of these 60 charts were considered deficient (50 percent).

¹ A management review is any type of chart review that is conducted for purposes other than confidential quality improvement related to decisions affecting individual providers. Management reviews are not protected by 38 U.S.C. § 5705; examples that fall under this classification are: Administrative Investigation Boards, OPPE and FPPE, and clinical reviews. OPPE is 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. VHA Directive 2010-025, *Peer Review For Quality Management*, June 3, 2010. http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2250. See also VHA Handbook 1100.19, *Credentialing and Privileging*, paragraph 14 g. and l., October 15, 2012. http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2910.

² The previous ACoS, PC, and top leadership at the Medical Center from 2009 to 2013 no longer work at the Medical Center, and were not available for questioning. The current Medical Center Director started in April 2012, the ACoS, PC, started in December 2013, and the CoS in January 2014.

³ Professional Standards Boards (PSB) act for, are responsible to, and are agencies of the USH in matters concerning appointments, advancements, and probationary reviews of physicians, dentists, podiatrists, chiropractors, optometrists, APRNs, and PAs. Boards will determine eligibility and recommend the appropriate grade for appointments under authority of 38 U.S.C. §§ 7401(1) and 7405(a)(1)(A); recommend candidates for advancements; and conduct probationary reviews. VA Handbook 5005/17, *Staffing*, June 15, 2006. The members of

VA reviewed documentation showing that the ACoS, PC, met with the NP on June 4 to discuss the results of the unprotected clinical review. She noted that the NP "verbalized understanding, requesting to meet with her again to actually go through some of the charts." On June 19, based on these reviews, the ACoS, PC, recommended to the CoS and Medical Center Director that this NP's clinical privileges should be suspended until the results of the unprotected clinical review could be presented to the PSB. The standard for taking a summary suspension of privileges is "when failure to take such action may result in imminent danger to the health of any individual." The clinical care being provided to Veterans was deemed poor, therefore, such a threat existed. The ACoS, PC, was unable to explain the reason for the 2-week delay.

The PSB, which is chaired by the CoS, met a second time the following day, examined the data, and recommended "revocation of privileges" for substandard care. Based on this recommendation, the Medical Center Director summarily suspended the NP's clinical privileges, pending comprehensive review and due process. The Clinical Executive Board (CEB) was scheduled to meet on July 8, 2014, to hear the PSB's recommendation to revoke this NP's privileges. On June 25, the CoS provided VISN 16 leadership with the results of the unprotected clinical review. On June 30, the NP submitted a letter of resignation, effective NP (b6) 2014, to the ACoS, PC. Because the NP had resigned, the CEB meeting scheduled for July 8 was not held.

According to VHA Handbook 1100.18, 5a, *Reporting and Responding To State Licensing Boards*, VHA facilities must report on their own initiative each licensed health care professional whose behavior or clinical practice so substantially fails to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients. The handbook requires the initiation of an initial review of the individual's clinical practice within seven calendar days of the date the individual leaves VA employment or information is received that suggests the clinical practice of a current licensed practitioner has met the reporting standard, to determine if there may be substantial evidence that the individual's clinical practice met the standard for reporting. The clinical review of the care provided to each of the NP's patients was initiated in July 2014, 1 month after concerns regarding practice were identified by the unprotected clinical review. However, as of the date of the May 2015 site visit to investigate OSC File Numbers DI-14-3209, 4305, 5078, Medical Center leadership had not initiated any further procedures to report the NP to the state SLB, but planned to do so following our site visit.

Licensure and Privileging Issues

During the 2013 DUSHOM-directed investigation of OSC File No. DI-12-3816, the Medical Center was found to be non-compliant with VA policy on NP licensure. At the time of that investigation, Medical Center policy allowed all NPs, regardless of their

the Board report to the CoS or designee who serves as the Chair, and makes recommendations regarding professional privileges of its members of the Medical Center Director.

under [REDACTED] Iowa license after December 2013 (the date when the ACoS, PC began her tenure), and it is not clear to what extent the NP may have voluntarily consulted with other provider colleagues during this time. The ACoS, PC, was not able to provide documentation to confirm whether the NP had ever been assigned to a collaborating physician or had worked under a nursing scope of practice at the Medical Center while practicing under [REDACTED] Mississippi license. The ACoS, PC noted, "Prior to receiving guidance on scopes of practice for NPs, [the NP] was an LIP without a collaborator," and the NP's letter of resignation states, "I have been through tough challenges in Primary Care including the lack of physician collaboration over the years..."

Prior to VA's May 2015 site visit, the ACoS, PC, and CoS were unaware of mandatory procedures to report the NP to the SLB, in accordance with the VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*; however, they have since initiated these actions. The ACoS, PC, and CoS should have been aware of this policy.

Conclusions for Allegation 1

- VA substantiated that an NP in the PCC regularly failed to provide sufficient care to patients. When this provider's care was identified in March 2014 as being below the standard of care, the ACoS, PC, and CoS immediately ordered a 90-day unprotected clinical review. After reviewing the results of this clinical review, Medical Center officials summarily suspended the NP's privileges on June 19, 2014, pending comprehensive review and due process. On June 30, 2014, the NP submitted a letter of resignation, effective NP (b6) 2014, thereby surrendering his privileges while under investigation for possible professional incompetence, improper professional conduct or substandard care, with the threat of revocation of his clinical privileges after their summary suspension.
- During the DUSHOM investigation in FY 2013 for OSC File No. DI-12-3816, VA found that, contrary to state law, this NP had practiced at the Medical Center without a collaborator while working under NP (b6) Mississippi license.
- While employed at the Medical Center, this NP engaged in conduct that constituted violations of Mississippi laws, which led to a substantial and specific danger to public health and safety.
- Prior to the FY 2013 DUSHOM investigation, the current ACoS, PC and CoS were not in leadership positions at the Medical Center. When deficiencies in the NP's clinical practice were identified in the 90-day unprotected clinical review completed in June 2014, the current clinical leadership acted upon them. The former clinical leadership is no longer employed within VA. Following the NP's resignation and voluntary surrender of privileges on NP (b6) 2014, the facility initiated a clinical review on July 29, 2014, of the care provided by the NP to each of [REDACTED] patients. VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, requires

the initiation of a review of an individual's clinical practice within seven calendar days of when a licensed practitioner leaves VA employment or information is received that suggests the clinical practice of a current licensed practitioner has met the reporting standard to determine if there may be substantial evidence that the individual so substantially failed to meet generally-accepted standards of clinical practice as to raise reasonable concern for the safety of patients.

- o Following the May 2015 VA site visit, the ACoS, PC, and CoS initiated mandatory procedures to report the NP to the SLB, in accordance with the VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*; however, these procedures were not initiated immediately.
- o Accountability actions are warranted regarding the delay in initiating the clinical review and beginning the process to report the NP to the SLB.

Recommendations to the Medical Center

1. Complete the mandatory procedures to report the NP to the SLB, in accordance with the VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*.
2. Offer the NP a "limited fair hearing" notice to determine whether [REDACTED] knew [REDACTED] was under investigation for substandard care, professional misconduct, or professional incompetence when [REDACTED] resigned and surrendered [REDACTED] clinical privileges.
3. Ensure that all APRNs are working in accordance with the rules and regulations of their state licensure, and take appropriate corrective actions as indicated.

Recommendation to VHA

4. Determine leadership accountability for the delays in initiating the clinical review and beginning the process to report the NP to the SLB, in accordance with VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*.

Allegation 2

As a result of this failure to provide adequate care, patient health was placed in jeopardy.

Findings

Following the NP's resignation, the ACoS, PC, initiated an unprotected clinical review of all of his EHRs on July 29, 2014, by assigning PC providers a portion of them to review. The providers were instructed to address any and all clinical issues requiring follow up, including instances where there was no evidence that the results of laboratory or radiological tests had been communicated to the patient; instances where surveillance tests for diseases had been performed, but there was no documentation of the diagnosis or of subsequent appropriate care; and instances of failure to intervene or

provide appropriate medical care for patients, such as in cases of uncontrolled diabetes or blood pressure. The clinical reviews were completed on September 5, 2014.

The reviewers provided medical care and intervention to all patients as indicated, and provided the Deputy ACoS, PC, with the names of 16 patients who might have been harmed or who might need additional care. The Deputy ACoS, PC, continues to provide follow-up care to these patients.

VA reviewed the EHRs of these 16 Veterans for whom this NP provided inadequate care. Of these, two Veterans experienced significant delays in care resulting in delays in the diagnosis of Patient 1 (b6) in one Veteran and of advanced stage Patient 2 (b6) in the second. The Medical Center completed Institutional Disclosures on these two Veterans on May 14 and 15, 2015.⁷

One of the whistleblowers, Employee 2 (B6), provided 14 examples of suboptimal patient care that demonstrated this NP's failure to address abnormal laboratory values and physical parameters — such as elevated blood pressure readings and abnormal laboratory results — resulting in poor control and progression of chronic diseases. VA reviewed these EHRs and noted that they were included in the group of Veterans that the Deputy ACoS, PC, is following.

After evaluating the results of the unprotected clinical review and interviewing the Deputy ACoS, PC, we confirmed that the medical care provided by the NP was substandard and concur with Employee 2 (B6) concerns that the NP's failure to provide adequate care placed patients in jeopardy. All Veterans identified by Employee 2 (B6) had been identified during the July-September 2014, clinical review of the NP's patients, and are receiving appropriate follow up care.

During interviews, some providers who reviewed the NP's charts reported that there was a lack of follow up on patient care issues. Several staff members said that [redacted] neglected to enter orders to have patients return for timely follow up, so that [redacted] patients were scheduled to return to the clinic at prolonged intervals. Additionally, the NP accumulated high numbers of unaddressed clinical alerts (over 1400 at one point in time), far exceeding the numbers of similar PC providers.⁸ Unaddressed clinical alerts pose a risk for delays in care. Several staff members noted that the NP had been willing to address [redacted] clinical alerts by working on Saturdays, but PC leadership was unable to grant overtime for this task. Several NPs reported that they were not normally

⁷ Institutional disclosure of adverse events is a formal process by which the Medical Center leadership, together with clinicians and other appropriate individuals, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in or is reasonably expected to result in death or serious injury. A clinical disclosure is a similar process where the patient's clinician informs the patient or the patient's personal representative that a harmful or potentially harmful adverse event has occurred during the course of care. A clinical disclosure is appropriate for all adverse events that cause only minor harm to the patient, except those minor harms that are discovered after the patient has completed the associated episode of care and that have no implications for the patient's future health, in which case disclosure may not be indicated. VHA Handbook 1004.06

⁸ A clinical alert is an electronic message that appears on the CPRS login screen informing the clinician that an action may be necessary to address an item in the record. Examples of clinical alerts are messages that inform the clinician of the status of a consultation request, or the urgent need to manage an abnormal laboratory result.

Bradley, Siobhan Smith

From: Nguyen, Nhi <Nhi.Nguyen@va.gov>
Sent: Thursday, December 10, 2015 4:46 PM
To: McMullen, Catherine; Biggs, Tracy
Cc: Miranda, Bonnie; Bradley, Siobhan Smith
Subject: FW: OSC File No. DI-14-3209, DI-14-4305 and DI-14-5078, Jackson, MS
Attachments: Jackson DI-14-3209, 4305, 5078 Part 2b.pdf

Part 2b for Jackson is attached.

Nhi Nguyen
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From: McMullen, Catherine [<mailto:CMcMullen@osc.gov>]
Sent: Thursday, December 10, 2015 4:07 PM
To: Nguyen, Nhi; Biggs, Tracy
Cc: Miranda, Bonnie; Bradley, Siobhan Smith
Subject: [EXTERNAL] RE: OSC File No. DI-14-3209, DI-14-4305 and DI-14-5078, Jackson, MS

We did not receive Part 2. Thanks.

From: Nguyen, Nhi [<mailto:Nhi.Nguyen@va.gov>]
Sent: Thursday, December 10, 2015 4:02 PM
To: McMullen, Catherine; Biggs, Tracy
Cc: Miranda, Bonnie
Subject: FW: OSC File No. DI-14-3209, DI-14-4305 and DI-14-5078, Jackson, MS

This is Part 1b for Jackson. Did Part 2 come through?

Nhi Nguyen
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From: Nguyen, Nhi
Sent: Wednesday, December 02, 2015 10:00 AM
To: McMullen, Catherine (CMcMullen@osc.gov); Biggs, Tracy (TBiggs@osc.gov)
Cc: Miranda, Bonnie
Subject: OSC File No. DI-14-3209, DI-14-4305 and DI-14-5078, Jackson, MS

Good morning, Catherine and Tracy-
Attached is the redacted file for Jackson. Due to the size of the file after redactions were made, it was too large to send via email, and we had to split the file into 2 parts. Attached is part 1. Part 2 will follow momentarily.

Please let us know if you need anything further.

Nhi

Nhi Nguyen

Acting Deputy Executive Secretary/Executive Writer
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allowed overtime to complete their alerts, but overtime was granted for the NPs to complete the NP's alerts after [redacted] resigned. The ACoS, PC, was not aware of the number of clinical alerts pending for the NP's patients until shortly before [redacted] resigned.

At the time that the NP worked in PC, several physician providers had remote access to the EHR, but the NPs did not. All providers agreed that the number of clinical alerts generated in the course of patient care was excessive — at times unmanageable — and that alert management was stressful. Some NPs expressed a desire for remote access to computerized patient record system (CPRS) in order to allow them to manage clinical alerts from home. Although brought up as a concern by one of the whistleblowers, there are currently no unaddressed clinical alerts awaiting action by this NP or any other provider who no longer works at the Medical Center.

In our review of the patient advocate tracking system (PATS) for complaints about this NP from January 2013 through July 2014, we found a total of 34 complaints, half of which (17 of 34) were related to delays in getting medications and lack of confidence or trust in the provider. Other complaints pertained to unanswered or unreturned telephone calls, excessive delays in scheduling or rescheduling appointments, and the patient or family members not agreeing with the care provided.

Conclusions for Allegation 2

- VA substantiated that as a result of the NP's failure to provide adequate care, patient health was placed in jeopardy. Specifically, two Veterans experienced delays in diagnosis of advanced cancer while other patients experienced adverse events as a result of the NP's failure to properly manage their chronic conditions or respond to abnormal test results. The Deputy ACoS, PC, is currently monitoring patients where clinical concerns were identified.
- The Medical Center completed Institutional Disclosures on May 14 and 15, 2015, with the two Veterans who experienced delays in cancer diagnosis.

Recommendations to the Medical Center

5. Conduct external peer reviews of all of the NP's patients who experienced adverse events, and take appropriate action as defined in VHA Handbook 1004.08, *Disclosure of Adverse Events to Patients*.
6. Continue to monitor patients found to have quality of care concerns, specifically those on the Deputy ACoS, PC's patient list, and provide appropriate follow-up care as needed.
7. Consider providing remote access to EHRs for all PC providers in order to allow them to complete clinical work while away from the Medical Center.

Allegation 3

Management was aware of these deficiencies for several years, but took no action to correct them until the nurse practitioner left the facility.

Findings

Professional Practice Reviews

As previously discussed under Allegation 1, concerns arose about the NP's practice following a review of data obtained in response to the 2013 DUSHOM-directed OSC site visit. In March 2014, the current CoS and ACoS, PC, removed the NP from direct patient care and initiated an unprotected clinical review. When the unprotected clinical review revealed evidence of substandard care, the CoS and ACoS, PC, convened the PSB on June 19, 2014, and the NP's clinical privileges were summarily suspended pending comprehensive review and due process. The CEB was scheduled to meet on July 8, 2014, to hear the PSB's recommendation to revoke the NP's privileges. On June 25, the CoS notified VISN 16 leadership of these facts. On June 30, 2014, the NP submitted [redacted] letter of resignation, effective NP (b6) 2014, thereby surrendering [redacted] privileges while under investigation for possible professional incompetence, improper professional conduct or substandard care. Since the NP had surrendered [redacted] privileges, the CEB did not meet on July 8, 2014, to hear the PSB's recommendation for revocation of privileges.

Subsequently, on July 29, the ACoS, PC, assigned each PC provider to review 24 to 30 of the NP's 718 assigned patients' EHRs. Upon completion of this unprotected clinical review on September 5, 2014, it was clear that the NP had failed to provide adequate care to many of [redacted] patients; that [redacted] had failed to follow up on abnormal laboratory values; that [redacted] had not requested consultation with medical and surgical subspecialists when indicated; and that [redacted] had not responded to numerous clinical alerts. In addition, there was evidence that at least two Veterans (those mentioned under allegation 2) had suffered harm due to this failure.

The Deputy ACoS, PC, continues to follow patients about whose care concerns were raised, to ensure that their care needs are appropriately addressed, and to determine whether any additional cases warrant clinical or institutional disclosure.

Privileging Actions

The NP was granted initial clinical privileges on NP (b6) [redacted]. During our June 3 teleconference call, we asked the ACoS, PC, how the Medical Center assesses the quality of care provided to Veterans by PC providers, and she discussed the OPPE and FPPE process, as well as peer review.⁹ She admitted that she was behind in

⁹ Peer review for QM purposes, as described in VHA Directive 2010-025, is intended to promote confidential and non-punitive processes that consistently contribute to quality management efforts at the individual provider level. Although organization systems issues are sometimes identified, the primary goal is overall improvement in the care provided to Veterans through a review of individual provider decisions and actions. It is expected that peer review done for quality management fosters a responsive environment where issues are identified, acted upon proactively,

documenting OPPEs, and that the OPPE process did not take place every 6 months, as required.

The NP's clinical privileges file includes OPPEs dating back to 2011. Between 2011 and 2013, only one OPPE raised concerns about deficiencies in care. The OPPE completed during the first 6 months of FY 2013, dated May 14, 2013, documented marginally acceptable performance evaluations based on "concerns regarding clinical practice." An OPPE completed 3 months later rated the NP as fully satisfactory, and [REDACTED] remained fully satisfactory until the VISN 16 external clinical reviews were completed and the unprotected clinical review initiated in March 2014. Following a December 2013 OPPE, the NP was evaluated according to the Medical Center's policy on *Credentialing and Privileging*, and [REDACTED] was re-privileged accordingly. The ACoS, PC, admitted that she did not review the NP's EHRs herself; in recommending continuation of [REDACTED] privileges, she had relied on the review of other PC physician providers.

The NP received satisfactory and high satisfactory proficiency evaluations (also referred to as performance ratings) from FY 2011 through FY 2012; performance evaluations prior to this date were not available.

In June 2014, the unprotected clinical review referenced above noted, "[The NP] was found to be unsatisfactory due to findings on multiple chart reviews." Specifically, the unprotected clinical review rated [REDACTED] clinical practice as unsatisfactory in four categories: ER visits per 100 patients; cut-and-paste notes; diabetics with poorly controlled cholesterol; and clinical alert management. For example, on June 27, 2014, [REDACTED] had 1,642 clinical alerts requiring his action. [REDACTED] had no patient complaints during this period. The ACoS, PC, reported that she was unaware of any issues with his care delivery or of his patient chart deficiencies until notified by VISN 16 in early 2014.

During interviews, all PC staff reported that the NP was slow to act upon patient care needs and had numerous unmanaged clinical alerts; however, no provider reported having knowledge of quality of care concerns until the results of the VISN 16 chart reviews were known.

One MSA who worked with the NP stated that [REDACTED] had many unanswered calls from patients seeking medication renewals, and that [REDACTED] routinely wrote follow up "return to clinic orders" before seeing patients, a result of [REDACTED] practice of entering and signing clinical encounter notes prior to seeing the patients - an observation that was confirmed by several other staff members. The MSA also explained that, in general, the NP took a long time to complete work, such as entering consultation requests and ordering follow up appointments. The RN, LPN, and MSA all asserted that they had reported their concerns to their immediate supervisors. The Nurse Manager and MSA Supervisor said that their respective staff had complained to them in May 2014, and they had in turn informed the ACoS, PC, who had then spoken with the NP. The ACoS, PC, described

and in ways that continually contribute to the best possible outcomes and strong organizational performance. Peer Review for QM is protected from discovery under 38 U.S.C. § 5705.

her conversation with the NP as one during which she expressed the expectations of each PC provider, to include the timely management of patient care issues.

Several other MSAs noted that this NP created and signed [redacted] notes prior to actually seeing patients, but they failed to report these issues to their supervisor. Additionally, while some nursing staff members reported deficiencies in this NP's patient care, they had not reported their concerns beyond their immediate supervisor.

The VA team found that the OPPE process is not completed every 6 months as required by VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010, and the content of the evaluation does not vary, as expected, by clinical area. The CoS is reviewing the current FPPE and OPPE processes that were in place while this NP was in clinical practice to identify opportunities to strengthen the processes at the Medical Center.

The VA team found that issues regarding this NP's clinical care should have been identified through the OPPE process. The last OPPE completed is dated after the NP's resignation, and there is a note in [redacted] privileging records pertaining to a previously lost FPPE. If this NP's practice had been properly monitored through the OPPE process from FY 2009 through FY 2012, or if [redacted] has been assigned a collaborating physician per Mississippi law, someone should have identified these deficiencies in clinical care.

Conclusions for Allegation 3

- **VA did not substantiate that Management was aware of these deficiencies for several years, but took no action to correct them until the NP left the facility. We found evidence that the deficiencies were first identified and acted upon by the current Medical Center's clinical management, including the ACoS, PC, and CoS. The Medical Center Director heeded their concerns and took appropriate administrative action in 2014, when these issues were identified. As a result, no additional accountability actions are warranted.**
- **We reviewed this NP's personnel record and credentialing and privileging file, examined other documentation, conducted interviews, and found no evidence that the current management was aware of the deficiencies prior to receiving the results of the December 2013 VISN 16 protected peer review clinical review results in February 2014.**
- **VA found that the OPPE was not initiated in a timely manner, since this NP was hired in [redacted] and the first OPPE was not completed until 2011. VA also found that current OPPEs were not completed in accordance with VHA Directive 2010-025. Accountability actions are warranted since clinical leadership is responsible for ensuring the timely, thorough completion of OPPEs.**
- **VA found no evidence that current PC leadership was aware of this NP's extensive use of cut-and-paste notes, templates, and lack of follow up on clinical alerts or**

Bradley, Siobhan Smith

From: Nguyen, Nhi <Nhi.Nguyen@va.gov>
Sent: Thursday, December 10, 2015 4:48 PM
To: McMullen, Catherine; Biggs, Tracy
Cc: Miranda, Bonnie; Bradley, Siobhan Smith
Subject: FW: OSC File No. DI-14-3209, DI-14-4305 and DI-14-5078, Jackson, MS
Attachments: Jackson DI-14-3209, 4305, 5078 Part 2c.pdf

Part 2c for Jackson is attached. This should be it. Please let us know if you did not receive 2a or 2b. Thank you!

Nhi Nguyen
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From: McMullen, Catherine [<mailto:CMcMullen@osc.gov>]
Sent: Thursday, December 10, 2015 4:07 PM
To: Nguyen, Nhi; Biggs, Tracy
Cc: Miranda, Bonnie; Bradley, Siobhan Smith
Subject: [EXTERNAL] RE: OSC File No. DI-14-3209, DI-14-4305 and DI-14-5078, Jackson, MS

We did not receive Part 2. Thanks.

From: Nguyen, Nhi [<mailto:Nhi.Nguyen@va.gov>]
Sent: Thursday, December 10, 2015 4:02 PM
To: McMullen, Catherine; Biggs, Tracy
Cc: Miranda, Bonnie
Subject: FW: OSC File No. DI-14-3209, DI-14-4305 and DI-14-5078, Jackson, MS

This is Part 1b for Jackson. Did Part 2 come through?

Nhi Nguyen
Executive Writer
(202) 461-7015

From: Nguyen, Nhi
Sent: Wednesday, December 02, 2015 10:00 AM
To: McMullen, Catherine (CMcMullen@osc.gov); Biggs, Tracy (TBiggs@osc.gov)
Cc: Miranda, Bonnie
Subject: OSC File No. DI-14-3209, DI-14-4305 and DI-14-5078, Jackson, MS

Good morning, Catherine and Tracy-
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Please let us know if you need anything further.

Nhi

Nhi Nguyen

Acting Deputy Executive Secretary/Executive Writer
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patient issues until the VISN's external clinical review and the Medical Center's subsequent FPPEs were completed.

- o When clinical concerns were noticed by some MSAs and nursing staff members, they did not bring their concerns to the attention of their respective administrative and nursing clinical managers.

Recommendations to the Medical Center

8. The CoS should continue to review the Medical Center's FPPE and OPPE processes and take actions to ensure that they are completed timely by the ACoS, PC, and that there is variation in the content based upon clinical area.
9. Provide education to ensure a culture of transparency and a willingness to report concerns to management and leadership.

Allegation 4

The current plan to address the nurse practitioner's patient charts does not constitute a thorough review of potential harm to patients and places patients at further risk for substandard care.

Findings

Following the NP's resignation, the ACoS, PC, directed all PC providers, including physicians and NPs, to complete a clinical review in the form of a standardized template to determine whether any of the NP's former patients required additional follow up care. We reviewed the content of the email that the ACoS, PC, sent to these providers, and noted that it included instructions that clearly stated the goals of the clinical review, and its intent to assess whether any patients had been harmed and whether follow up actions were required. Although these activities were conducted by the NP's professional peers, appropriately, since there was a concern regarding patient safety, they did not constitute a "peer review" for quality management purposes.

Several physician providers said that they did not wish to participate in the chart reviews. They noted that NPs received compensatory time for reviewing the charts, while physicians did not. Some reported that they were uncomfortable recommending follow up care when they had not examined the patients face-to-face. Eventually, all PC providers completed the review process after several additional directives from the ACoS, PC.

Following completion of the reviews, the Deputy ACoS, PC, completed an additional evaluation of all patients identified as having had adverse events or requiring additional follow up, and she continues to follow those patients.

During our interviews, we found that most PC providers seem to lack an understanding of the difference between peer reviews, and clinical reviews. When asked whether they participated in a peer review process for QM, all stated that they were "peer-reviewed" every 6 months — a clear reference to OPPEs. There did not seem to be any

recognition of the link between OPPEs and re-privileging; the OPPEs were viewed as benign and non-punitive. When queried about peer review for QM, the providers that we interviewed stated that this was rare, extremely stressful, and could result in disciplinary action. While they indicated that the QM department is responsible for peer reviews for QM and that PC department administrators are responsible for FPPEs and OPPEs, both processes were described as "peer reviews." Some providers did recognize that peer reviews could be conducted in cases of patient death, harm, or as part of routine care, and that FPPEs and OPPEs were a part of the Medical Center's ongoing quality assurance program. Other providers were unclear of the distinct roles that these entities play.

There are currently seven NPs who have clinical privileges, and therefore, function as LIPs because their states of licensure permit this. Four other NPs, working under Mississippi licenses and a nursing scope of practice, have been assigned physician collaborators. At the time of VA's site visit, neither the NPs nor the collaborating physicians were provided protected nonclinical time to meet.

During late FY 2015, through application of the FPPE and OPPE process, the ACoS, PC, removed two NPs from clinical duties, and gave them administrative duties pending further evaluation of their practice.

The Deputy ACoS, PC, is continuing to review, monitor, and track all patient cases of concern to determine the quality of care provided by NPs, and is monitoring overall practice for all providers to ensure clinical competency.

Conclusions for Allegation 4

- VA did not substantiate that the current plan to address the NP's patient charts is inadequate, and therefore, does not place patients at further risk for substandard care.
- VA found that several PC providers are confused about the difference between FPPEs, OPPEs, peer reviews, and clinical reviews.

Recommendations to the Medical Center

10. Review quality management (QM) policies and:

- Reeducate all applicable, clinical staff on the difference between the FPPE, OPPE, and peer review processes, with emphasis on the non-punitive nature of peer review for QM purposes.
- Use peer review to assess routine care, not just in cases where adverse events or unanticipated outcomes have occurred.
- Ensure that peer review for QM is not used as a proxy for a clinical review, which carries the potential for negative administrative consequences for the provider being reviewed.

11. Request a consultative visit from the Office of Quality Safety and Value pertaining to the Medical Center's compliance with VHA Directive 2010-025, *Peer Review for Quality Management*. Review the Medical Center's FPPE and OPPE processes to ensure compliance with VHA policy in VHA Directive 2010-025 and VHA Handbook 1100.19, *Credentialing and Privileging*.
12. Provide protected administrative time for NPs, as well as all PC providers in accordance with VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook*.

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*.

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

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

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

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.

Medical Center Patient Advocate Tracking System complaints pertaining to the NP, 2013-2014.

Medical Center Nursing Professional Standards Board (NPSB) Minutes pertaining to the NP, March 11 and June 19, 2014.

Credentialing and Privileging folder of the NP.

OPPEs and FPPEs for the NP 2009-2013.

Patient Alert List for Primary Care