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The Special Counsel

December 21, 2016

The President
The White House
Washington, D.C. 20510

Re: OSC File Nos. DI-14-3209, DI-14-4305, and DI-14-5078

Dear Mr. President:

Pursuant to my duties as Special Counsel, I am forwarding a report based on disclosures of wrongdoing at the Department of Veterans Affairs (VA), G.V. (Sonny) Montgomery VA Medical Center (Jackson VAMC). I have reviewed the VA report in accordance with 5 U.S.C. § 1213(e) and provide the following summary of the investigation, the whistleblowers' comments, and my findings.[1]

I received these disclosures from three whistleblowers: one whistleblower whose identity remains confidential; Mr. Kim Washington, a former medical supply technician in the Primary Care Clinic; and Dr. Phyllis Hollenbeck, a physician in the Compensation and Pension Clinic. Collectively, the whistleblowers disclosed that a nurse practitioner (NP) in the Primary Care Clinic at the Jackson VAMC regularly failed to provide sufficient care to patients, placing patient health in jeopardy. The whistleblowers further disclosed that management was aware of these deficiencies for several years, but took no action to correct them until the NP left the facility. Finally, the whistleblowers disclosed that the agency's plan to address the NP's charts did not constitute a thorough review of harm to patients and placed them at further risk for substandard care.

I referred the whistleblowers' allegations to Secretary of Veterans Affairs Robert A. McDonald on March 27, 2015 for investigation pursuant to 5 U.S.C. § 1213(c). Secretary

[1] The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety. 5 U.S.C. § 1213(a) and (b). OSC does not have the authority to investigate a whistleblower's disclosure; rather, if the Special Counsel determines that there is a substantial likelihood that one of the aforementioned conditions exists, she is required to advise the appropriate agency head of her determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c). Upon receipt, the Special Counsel reviews the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). The Special Counsel will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

McDonald forwarded the allegations to the Interim Under Secretary for Health, who directed the Office of the Medical Inspector (OMI) to conduct the investigation. Secretary McDonald delegated responsibility to submit the agency report to then-VA Chief of Staff Robert L. Nabors, who submitted the report on December 1, 2015. Dr. Hollenbeck and Mr. Washington provided comments regarding the agency report. The confidential whistleblower declined to comment on the report.

OMI's investigation substantiated the allegation that an NP in the Primary Care Clinic failed to provide sufficient care to patients. Specifically, OMI determined that in March 2014, VA officials found the NP's treatment of patients to be below the standard of care, and determined that this lack of adequate care placed patient health in jeopardy. Subsequently, in March 2014, the Primary Care Chief of Staff (CoS) and Associate Chief of Staff (ACoS) ordered a 90-day unprotected clinical review of the NP's patients. After reviewing the results, Jackson VAMC 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 July 7, 2014. Through its investigation, OMI also determined that while employed with the VA, the NP failed to work with a physician collaborator, as required under Mississippi state nursing licensing law.

OMI's investigation did not substantiate either that current VA management was long aware of, but failed to address the NP's deficiencies, or that the current plan to address the NP's charts was inadequate and placed patients at further risk. OMI did find that agency officials failed to report the NP's misconduct to the state licensing board until May 2015, almost one year after becoming aware of it. OMI also found through a review of agency records that, though the NP was hired in 2009, management did not conduct any ongoing professional practice evaluations (OPPEs) of his work until 2011. Based on its investigation, OMI made several recommendations to the VA to ensure future compliance with agency directives, provide ongoing follow-ups with each of the NP's former patients, and institute accountability actions against officials responsible for the lapse in oversight.

In her comments, Dr. Hollenbeck expressed concern that an ongoing lack of clinical oversight of NPs within the Jackson VAMC creates a danger to patient health and safety. She also cautioned that if the Jackson VAMC adopted recently-proposed VA directives allowing nurse practitioners to practice independently without doctor supervision, patients at the medical center would continue to receive substandard care. Mr. Washington also commented on the report but did not focus on the allegations concerning the NP.

I have reviewed the disclosures, the agency report, and the whistleblowers' comments. I note that had the VA conducted timely OPPEs of the NP's charts, as required under VA directives, officials may have discovered the issue earlier and potentially avoided harm to patients. I also acknowledge Dr. Hollenbeck's ongoing concern about better oversight of NPs providing care to veterans. I am encouraged, however, that the VA has recently implemented each of OMI's recommended actions, including counseling agency officials responsible for the lapse in OPPEs. Accordingly, I have determined that the report contains all of the information required by statute and the findings appear reasonable.

I have sent a copy of this letter, the unredacted agency report, and the whistleblowers' comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed a copy of this letter, the redacted agency report and the whistleblowers' comments in OSC's public file, which is available online at www.osc.gov. This matter is now closed.

Respectfully,

Carolyn N. Lerner

Enclosures