THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

November 21, 2024

The Honorable Hampton Dellinger
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

Re: Office of Special Counsel File No. DI-24-000312

Dear Mr. Dellinger:

I am responding to your January 24, 2024, letter to the Department of Veterans Affairs (VA) regarding whistleblower allegations that the Lt. Colonel Charles Kettles VA Medical Center (VAMC), Ann Arbor, Michigan, failed to meet the criteria necessary to maintain its designation as an Inpatient Complex facility for inpatient invasive procedures.

The results of the Office of Inspector General's (OIG) investigation are in the enclosed report. OIG substantiated two allegations and did not substantiate two allegations. OIG made six recommendations to include three recommendations to the Ann Arbor VAMC, two recommendations to the Under Secretary for Health, and one to the Network Director of the VA Health Care System serving Ohio, Indiana, and Michigan.

Thank you for the opportunity to respond.

Sincerely,

Denis McDonough

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL
WASHINGTON, DC 20420

November 15, 2024

MEMORANDUM

TO: Office of Special Counsel

FROM: VA Office of Inspector General

SUBJECT: Report of Investigation re OSC Referral DI-24-000312

Introduction

On January 24, 2024, the Office of Special Counsel (OSC) made a referral to the Department of Veterans Affairs (VA) of allegations received from [redacted], former Chief of the Surgical Critical Care Service at Ann Arbor VA Medical Center (Whistleblower). The allegations in the OSC referral were similar to concerns that had previously been reported to the OIG's hotline and that the OIG was already investigating. The Office of Inspector General (OIG) accepted the OSC referral and investigated Whistleblower's allegations.

The OSC referral indicated that the Whistleblower reported allegations of patient safety concerns and violations of Veterans Health Administration (VHA) regulations, Joint Commission standards for healthcare organizations, and statutory requirements. Specifically, the Whistleblower alleged that Ann Arbor VAMC

- violated VHA Directive 1220 requirements for the facility to have a designation of Inpatient Complex for inpatient invasive procedures;
- violated Joint Commission standards regarding documentation of complex or high-risk surgical procedures;
- violated the Health Insurance Portability and Accountability Act (HIPAA) by providers discussing protected health information (PHI) in the public waiting room of the facility; and
- permitted unauthorized access to VA computer systems by physician residents who did not have credentials approved by the VA.

OIG health care inspectors interviewed Whistleblower on February 16 and 22, 2024. OIG health care inspectors then conducted a site visit at Ann Arbor VAMC from April 2, 2024, through April 4, 2024.

and interviewed approximately 30 individuals. OIG conducted additional virtual interviews through May 23, 2024.

OIG interviewed leaders from VHA national program offices, Veterans Integrated Service Network (VISN) surgical and education leaders, facility leaders and staff, and the affiliate surgical residency program director[1], VISN surgical and education leaders, and facility leaders and staff. OIG reviewed relevant VHA and facility policies and procedures, Joint Patient Safety Report (JPSR) data, organizational charts, committee meeting minutes, electronic communications, quality reviews, on-call schedules, and patient electronic health records (EHR).[2] OIG also reviewed relevant Joint Commission standards.

In the absence of current VA or VHA policy, OIG considered previous guidance to be in effect until superseded by an updated or re-certified directive, handbook, or other policy document on the same or similar issue(s).

OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Discussion

Allegation 1: Ann Arbor VAMC violated the VHA Directive 1220 requirements for the facility to have a designation of Inpatient Complex for inpatient invasive procedures.

Inpatient Surgical Coverage

OIG did not substantiate that the Surgery Service lacked coverage to ensure a provider was available on-call within 15 minutes by phone and within 60 minutes on-site, or that the facility lacked qualified inpatient coverage, as required for the invasive procedure complexity designation.

VHA policy requires a formal call schedule that includes 24/7 coverage by attending surgeons, fellows or residents in surgical training programs, or trained advanced practice providers

[1] The VHA Program Offices included the Office of Academic Affiliations (OAA), Office of Specialty Care, Diagnostic Services, National Radiology Program, and National Pathology and Laboratory Medicine.

[2] The OIG reviewed patient examples provided by Whistleblower and through JPSRs and included patient examples in this report only when relevant to a substantiated allegation or OIG concern.

available on-call within 15 minutes by phone and on-site within 60 minutes.[3] Additionally, "there must be qualified inpatient coverage in house for all inpatients."[4]

During the inspection, OIG reviewed surgical on-call schedules and patient cases provided by the Whistleblower as examples of a lack of required surgical coverage.[5] OIG found the facility used a schedule for surgeons to know when they were expected to be on-call and a paging system through the affiliate for facility staff to contact the scheduled on-call surgeon.[6]

OIG determined one of the patient cases provided by the Whistleblower involved an on-call attending surgeon who was not available within 60 minutes on-site. In an OIG interview, the chief of surgery described a communication escalation process, implemented in spring 2023, that addressed concerns related to provider response times and ability of staff to escalate concerns beyond residents when needed.[7] A facility patient safety specialist told OIG that effectiveness of the escalation process was monitored through review of patient safety reports. OIG reviewed patient safety reports related to surgical coverage and noted a decrease in the number of reports submitted involving difficulty reaching an on-call surgeon after implementation of the escalation process. Additionally, the reports entered after implementation did not reflect systemic difficulty reaching the covering surgeon. OIG verified with the chief of hospital medicine that the facility is continuously staffed by hospitalists, which meets the requirement for qualified in-house coverage for all inpatients.

OIG found the facility Surgery Service utilizes a formal call schedule for required surgical services, a mechanism to escalate challenges with reaching on-call surgical providers, and has qualified in-house coverage for all inpatients.

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[3] VHA Directive 1220(1). Advance practice providers are "qualified health care providers that work under the supervision of a licensed independent provider credentialed and privileged by the VA medical facility" and may include a certified registered nurse anesthetist, a nurse practitioner, or a physician assistant. The directive specifies the surgical specialty on-call requirement applies to Thoracic Surgery, Urology, Vascular Surgery, Cardiac Surgery, and Neurosurgery.

[4] VHA Directive 1220(1); "A 'physician or other qualified health care professional' is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service." American Medical Association, "CPT Evaluation and Management (E/M) Code and Guideline Changes," January 1, 2023, https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf.

[5] On-call schedules were provided for Thoracic Surgery, Urology, Vascular Surgery, Cardiac Surgery, Neurosurgery, Orthopedics, and General Surgery.

[6] The Chief of Staff reported to the OIG that the facility uses a "split model" with the affiliate whereby many surgeons work both for the facility and the affiliate.

[7] The escalation process specified a communication hierarchy beginning with the resident on-call and ending with the Chief of Staff. The document supporting this process provided to the OIG by a facility representative was referred to as a facility policy; however, the document did not include a policy number or signature. The OIG spoke with facility leaders and staff who were aware of the document and its contents; therefore, the OIG is confident this document has been widely accepted as a facility policy.

Delays in Infrastructure Waiver Requests

OIG substantiated that the facility lacked the required infrastructure supporting the assigned inpatient invasive procedure designation of *inpatient complex*. Specifically, the facility did not provide on-site interventional neuroradiology services or after hours on-call vascular and non-vascular interventional radiology and cardiac catheterization services.

VHA requires that facilities with the *inpatient complex* designation have vascular and non-vascular interventional radiology, a cardiac catheterization laboratory, and interventional neuroradiology services "available on-site during dayshift; at all other times, these services must be available on-call within 60 minutes."[8]

OIG learned that complexity waivers are generated at the facility level and routed through the VISN to VHA Clinical Services (Clinical Services) for review and final determination by a committee, which includes members from Specialty Care Services, the National Diagnostics Office, and the National Surgery Office.[9] OIG found that, although facility leaders pursued waivers for the lacking infrastructure requirements, the leaders did not submit the requests for approval until after OIG announced the inspection despite long-standing infrastructure gaps. OIG found delays in waiver requests and approvals resulted from

- facility leaders' lack of awareness of available surgical infrastructure,
- administrative delays at the VISN level, and
- conflicting guidance on waiver submission requirements provided by VISN leaders and Clinical Services staff.

In a December 2023 response to an OIG initial inquiry related to the Hotline complainant allegations, the Facility Director acknowledged a lack of on-site interventional neuroradiology services and stated that a waiver request was planned for submission to the VISN Director "pending completion of a formal [transfer agreement] with the [non-VA hospitals]." Following the announcement of the OIG inspection in February 2024, and in response to an OIG document request, OIG learned that the facility was planning to request waivers for vascular and non-vascular interventional radiology and cardiac catheterization due to lack of after hours on-call availability for these services. The chief of surgery submitted draft infrastructure waiver requests on March 4, 2024, five days after OIG notified facility leaders of the inspection. OIG learned through review of documentation provided by Clinical Services the waiver requests were signed by the VISN Chief Surgical Consultant and VISN Director on March 12, 2024. On April 29, 2024, Clinical Services approved a permanent waiver for cardiac catheterization laboratory services and a temporary (12 month) waiver for vascular and non-vascular interventional radiology.

[8] VHA Directive 1220(1). The requirement for interventional neuroradiology applies only to facilities with an approved VHA neurosurgery program. The facility has an approved neurosurgery program.

[9] Through review of email communication, the OIG learned the committee is called the Invasive Procedure Complexity Waiver Clinical Council. In interviews, the OIG learned that the committee may approve permanent or temporary waivers for specific infrastructure requirements and that the duration of temporary waivers varies.

However, the approval memorandum did not indicate review of a waiver for interventional neuroradiology services.

Delay in Identification of Need for Infrastructure Waivers

OIG learned that, while there had been long-standing deficiencies in infrastructure requirements, the chief of surgery was not aware of the lack of after hours on-call coverage for some services supporting the designation of *inpatient complex* despite completing the required annual review of infrastructure in November 2022.

Facility service chiefs are responsible for conducting an annual review of the available infrastructure, which must be certified by the facility director and VISN leaders, including the VISN Chief Surgical Consultant and the VISN Director.[10]

OIG reviewed the required annual reviews of infrastructure, which were completed by the chief of surgery in November 2022 and March 2024. In the annual review completed in November 2022, the chief of surgery endorsed deficiencies in interventional neuroradiology services, while indicating that the requirement was "fully met" for vascular and non-vascular interventional radiology and cardiac catheterization services. In the annual review completed in March 2024, the chief of surgery noted deficiencies with vascular and non-vascular interventional radiology services and cardiac catheterization services, as well as interventional neuroradiology services.

In an OIG interview, the Chief of Staff reported that the chief of surgery was responsible for completing the annual review of required invasive procedure infrastructure. The chief of surgery told OIG of first recognizing the need for a waiver for interventional neuroradiology in December 2022 while in the role of acting chief of surgery.[11] However, the chief of surgery told OIG of not identifying the lapses in interventional radiology and cardiac catheterization until completing an online checklist of infrastructure requirements in March 2024. OIG confirmed with facility leaders that the facility last had after hours on-call vascular and non-vascular interventional radiology coverage in December 2020, and that there had never been after hours cardiac catheterization services available at the facility.

The chief of surgery told OIG the previous chief of surgery did not clearly communicate infrastructure requirements or the need for waivers, stating "[the previous chief of surgery] hadn't done any of the waivers . . . I'm not sure [the previous chief of surgery] was aware . . . it wasn't something that was conveyed to me as being as critical."

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[10] VHA Directive 1220(1); Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "For Action: Annual Certification of Infrastructure Requirements for Sites Performing Invasive Procedures," memorandum. The annual review is accomplished through completion of the Invasive Procedure Infrastructure Inventory Tool (IPIIT).

[11] The chief of surgery told the OIG of serving in an acting role from August 2022 to February 2023 before becoming the permanent chief of surgery.

Conflicting Guidance on Waiver Requirements and Administrative Delays

OIG also found that the waiver request process was hindered by lack of clarity regarding the waiver process and requirements, and poor communication of the waiver request status between facility and VISN leaders.

VHA policy states that waivers may be granted when interventional cardiology, interventional neuroradiology, and non-vascular or vascular interventional radiology services are provided off-site, or when any infrastructure deficiency has undergone a risk assessment using the Healthcare Failure Mode Effect Analysis (HFMEA) process.[12] The VISN Director is responsible for submitting endorsed waiver requests to the Office of Specialty Care Services and the National Surgery Office.[13]

VHA policy also requires that infrastructure requirement waiver requests include

- the travel distance between the VA medical facility and the facility providing the service,
- a document establishing a transfer agreement, and
- a plan for monitoring and reviewing the quality of care being provided.[14]

In an interview with OIG, a facility deputy chief of staff (deputy chief of staff 1) reported that the waivers were not submitted to VISN leaders until March 2024 due to facility leaders' belief that the waiver submission required a formal patient transfer agreement with non-VA hospitals. Deputy chief of staff 1 reported that facility leaders were waiting to submit the waiver requests until the transfer agreements had been completed. In an interview, deputy chief of staff 1 told OIG of learning from the VISN specialty care integrated clinical community lead that the existing community care contract fulfilled the requirement for a transfer agreement in February 2024, and that additional transfer agreements were not necessary, and stated "it just felt . . . a little bit like a wasted effort."[15] The VISN Chief Surgical Consultant also told OIG of

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[12] VHA Directive 1220(1); An HFMEA is a healthcare focused prospective tool for proactive risk assessment meant to identify possible risks in a process before they occur. VHA National Center for Patient Safety, "Introduction and General Overview," *Guide to Completing Healthcare Failure Modes and Effects Analysis*, Version 3, February 2023.

[13] VHA Directive 1220(1).

[14] VHA Directive 1220(1). In addition to the listed requirements, the waiver request must also contain the infrastructure component for which the waiver is requested and the name of the facility performing the procedure. A transfer agreement can be documented in a memorandum of understanding or contract.

[15] A transfer agreement was completed with one non-VA hospital in March 2024, which the facility included with the waiver request for vascular and non-vascular interventional radiology and cardiac catheterization. Deputy chief of staff 1 told the OIG that the other transfer agreement was still in progress at the time of the site visit.

advising the facility that an additional transfer agreement would not be necessary if the non-VA hospital was part of the community care network.[16]

OIG found that the waiver approval memorandum provided by Clinical Services did not show review or approval of the waiver request for interventional neuroradiology. A VISN staff member informed OIG that facility leaders submitted a waiver request for interventional neuroradiology to the VISN in January 2024 without a required checklist. Although facility leaders submitted the checklist in March 2024, the VISN staff member stated that there was "some miscommunication," and the waiver request for interventional neuroradiology was "inadvertently overlooked" until submitted to Clinical Services in May 2024.[17]

In an interview, the VISN Chief Surgical Consultant told OIG of implementing a tracking mechanism for monitoring the status of waiver requests. OIG reviewed VISN surgical workgroup meeting minutes in which the workgroup identified the need for a waiver request tracking system in November 2023.[18] A VISN staff member provided a copy of the tracking spreadsheet in April 2024. Upon review, OIG found that the tracking spreadsheet erroneously indicated that the interventional neuroradiology waiver request had already been submitted to Clinical Services for approval.

In follow-up communication about the status of the interventional neuroradiology waiver request, a VISN staff member told OIG that a Clinical Services staff member had requested additional support for the waiver request, including documentation of a transfer agreement and evidence of an HFMEA. In August 2024, the VISN staff member told OIG through email correspondence that the HFMEA had been completed and submitted to Clinical Services. The Assistant Under Secretary for Health for Clinical Services approved the waiver on October 15, 2024, following review by the Invasive Procedure Complexity Waiver Clinical Council.[19]

OIG is concerned that the direction given from Clinical Services is not congruent with (1) information OIG received from the VISN Chief Surgical Consultant and (2) the VHA policy that addresses waiver request submissions. Specifically, it was not clear that an HFMEA was required for interventional neuroradiology waivers and there was conflicting guidance on

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[16] A community care network is a network of non-VA providers who, with approved agreements, provide care to veterans who cannot receive the service at a VA facility. VA, "Community Care Network (CCN) – Regions 1–5 For Community Providers" (fact sheet), January 27, 2022.

[17] The OIG learned, through review of email communication provided by the VISN staff member, that the chief of surgery submitted waiver request memos for interventional neuroradiology to the VISN in February 2023 and again in January 2024. The VISN staff member explained that the requests submitted by the facility in February 2023 and January 2024 lacked required information.

[18] Duties of the VISN surgical workgroup include ensuring facility compliance with infrastructure requirements. VHA Directive 1102.01(2), *National Surgery Office*, April 24, 2019, amended April 19, 2022.

[19] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Directive 1220 Waiver Request for Interventional Neuroradiology Services, Lt. Col. Charles S. Kettles Veterans Affairs Medical Center, (Station 506), Ann Arbor, Michigan (VIEWS 11966269)," memorandum to Director, Veterans Integrated Service Network 10 et al., October 15, 2024.

whether the community care contract fulfilled the requirement for a transfer agreement. These inconsistencies further delayed the waiver request process, which was already prolonged by facility leaders' lack of awareness of available infrastructure and administrative delays at the VISN level.

OIG determined that the facility lacked infrastructure requirements for vascular and non-vascular interventional radiology, cardiac catheterization, and interventional neuroradiology, but that the chief of surgery initiated waivers for these requirements after becoming aware of the deficiencies. OIG found that a lack of awareness of available services, unclear direction about waiver requirements, deficient tracking and communication of the waiver request status, and lack of VISN oversight led to delays in submission and approval of the waiver requests. Delays in waiver requests may lead to facilities operating at a complexity level without the required infrastructure, and without required review from relevant program offices.

Allegation 2: Ann Arbor VAMC violated Joint Commission standards regarding documentation of complex or high-risk surgical procedures.

OIG did not substantiate that facility surgeons failed to abide by facility bylaws and Joint Commission standards for postoperative documentation. While surgeons were not consistently completing a required operative note before patients were transferred to the next level of care, OIG found that facility leaders became aware of the issue prior to the inspection, and took action to monitor and improve compliance. However, OIG is concerned that the current monitoring methodology may result in inaccurate compliance data.

VHA states that healthcare providers are responsible for "[c]ompleting and authenticating (i.e., signing or co-signing) health record documentation within time frames defined by [VHA] directive, VA medical facility SOPs, guidelines and medical staff bylaws. . . ."[20] The facility bylaws require that "operative reports are to be dictated or written in the medical record immediately after surgery and must contain a description of the findings, the technical procedures used, the specimens removed, blood loss, complications, the postoperative diagnosis, and the names of the primary surgeon and any assistant."[21] Joint Commission standards for hospitals contain similar documentation content requirements related to operative reports and require that an operative report is written or dictated "before the patient is transferred to the next level of care."[22]

OIG reviewed facility Surgical Work Action Group (SWAG) committee minutes from April 2022–February 2024 and found that, in February 2023, committee members acknowledged

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[20] VHA Directive 1907.01(1), *VHA Health Information Management and Health Records*, April 5, 2021, amended December 11, 2023.

[21] Medical Staff Bylaws and Rules and Regulations of Veterans Health Administration (VHA), VA Ann Arbor Healthcare System, Ann Arbor, Michigan, July 24, 2023. The previous bylaws contained similar language regarding operative reports. Medical Staff Bylaws and Rules and Regulations of Veterans Health Administration (VHA), VA Ann Arbor Healthcare System, Ann Arbor, Michigan, September 2, 2021.

[22] The Joint Commission, *Standards Manual e-dition*, RC.02.01.03, January 2024.

concerns with operative note documentation.[23] Facility Surgery Service leaders and a deputy chief of staff (deputy chief of staff 2) initiated reporting of operative note documentation compliance through the SWAG committee in April 2023. OIG reviewed compliance data provided by the associate chief nurse for surgery and perioperative services (associate chief nurse) that showed, in March 2023, 62% of operative notes were documented as required by facility policy.[24]

OIG also learned of a complaint submitted to the Joint Commission regarding operative note documentation. The facility response to the Joint Commission in September 2023 indicated that staff received related training and facility leaders "established a protocol to identify and address documentation concerns." The Joint Commission reviewed the facility response and took no further action.

The chief of surgery told the OIG of actions taken to address completion of operative note documentation, including educating and sharing individual compliance data with providers. In December 2023, the SWAG committee minutes reflected an operative note compliance of 88%. To improve compliance, deputy chief of staff 2 facilitated implementation of a "hard stop" process, requiring completion of the operative note prior to patient discharge from the post anesthesia care unit (PACU). Compliance improved to 93% by the second half of December 2023 after this "hard stop" process was implemented.

While OIG recognizes the improvements in operative note completion, OIG identified a concern with the methodology used to monitor compliance, which placed the responsibility for ensuring completion of operative notes on PACU nurses. The associate chief nurse provided OIG with documentation indicating that from March 2023, through December 2023, the chief surgical nurse monitored compliance through random sampling of operative cases. However, in January 2024, deputy chief of staff 2 assigned PACU nurses the responsibility for tracking the surgical cases without an operative note prior to discharge from the PACU. The associate chief nurse explained that PACU nurses documented the cases without an operative note and the PACU manager divided this by the total number of cases through the PACU to calculate the compliance rate. The updated monitoring method revealed compliance rates of 99.5 % in both January and February of 2024.

OIG questions the reliability of the methodology used to measure compliance, which relies on nursing staff identifying cases of noncompliance, but without a retrospective audit to ensure that missing documentation is consistently captured. OIG would expect Surgery Service leaders to provide direct oversight of surgeon compliance with operative documentation requirements,

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[23] *Facility Surgical Workgroup (SWAG) Committee Charter*, July 13, 2023. The responsibilities of SWAG include facilitation of "transparent discussion[s] of surgical quality improvement data, practice and quality improvement, patient safety, outcomes data, and best practices." SWAG "serves as a formal reporting mechanism and provides operational oversight." The SWAG committee is co-chaired by the chief of surgery and associate nurse for surgery and perioperative services.

[24] The associate chief nurse for surgery and perioperative services provided documentation of postoperative note compliance monitoring from March 2023 through February 2024.

including conducting audits to verify completion of operative notes prior to patient transfer, rather than assigning responsibility to other clinical staff. Variables including nursing staff turnover and workload demands could affect how consistently PACU nurses identify missing documentation. If missing documentation is not identified, compliance may appear falsely high and increase the risk that important clinical information is unavailable to clinicians after an operative procedure.

Allegation 3: Ann Arbor VAMC violated the Health Insurance Portability and Accountability Act (HIPAA) by providers discussing protected health information (PHI) in the public waiting room of the facility.

OIG did not substantiate that facility providers violated HIPAA by discussing PHI in a public waiting room. To safeguard patient health information, VHA requires that employees "be conscious of when and where it is appropriate to discuss issues involving individually identifiable health information" and "[s]peak quietly when discussing a patient's condition with family members in a waiting room . . . or in other public areas."[25]

OIG observed the surgical waiting area (for families and friends of surgical patients) and noted the waiting area was a large open space with multiple rows of chairs located near offices and the intensive care unit. Additionally, OIG viewed an alcove adjacent to the waiting area and a room with a locked door labeled "COVID testing room."[26]

Facility surgeons told OIG of concerns with accessing private space to provide postoperative surgical updates. However, the surgeons denied awareness of privacy complaints and explained how private spaces for sensitive discussions could be accessed as needed. The chief of surgery told OIG of a renovation plan to create dedicated space for private discussions adjacent to the surgical waiting room using the space previously utilized for COVID screening.[27]

OIG learned no privacy complaints related to the surgical waiting area were reported to the privacy officer during the inspection review period.

Allegation 4: Ann Arbor VAMC permitted unauthorized access to VA computer systems to physician residents who did not have credentials approved by the VA.

OIG substantiated that facility leaders failed to ensure adherence to information security practices. Specifically, anesthesiology attending physicians provided unauthorized VA computer access to anesthesiology residents practicing in operating rooms. OIG found deputy chief of staff 2 was aware unauthorized access was occurring, but OIG was unable to determine if attending

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[25] VHA Directive 1605.01. Protected health information is "individually identifiable health information transmitted or maintained in any form or medium by a covered entity, such as VHA."

[26] The OIG did not witness any interactions between facility staff and the individuals in the waiting area.

[27] During the interview with the OIG, the chief of surgery reported being unaware of a renovation timeline.

physicians provided unauthorized access at the direction of deputy chief of staff 2, as alleged by the Whistleblower.

Unauthorized Access to VA Computer Systems

VHA requires that all facilities "must ensure that appropriate administrative, technical, and physical safeguards are established to ensure the security and confidentiality of personally identifiable information and records" including VA computer systems.[28] To obtain authorization to access VA computer systems, all system users must review and adhere to the "Rules of Behavior."[29] The "Rules of Behavior" describe "the minimal rules with which individual users must comply" including prohibiting users from unauthorized access and granting access to others.[30] Once computer access is authorized, "health care providers may access [the] EHR to facilitate and document medical care."[31]

During interviews, OIG learned that current and former anesthesia attending physicians provided unauthorized computer access in the operating room to anesthesia residents who lacked computer access at the start of a clinical rotation.[32] The attending physicians and an anesthesia resident described that attending physicians used their computer login credentials to facilitate resident access to the VA computer system and two electronic medical record programs so residents could view patient records and document anesthesia care. The attending physicians reported instances of leaving the operating room while a resident was logged into their account, allowing unauthorized and unmonitored computer access. In an interview, an attending physician told the OIG of signing the EHR documentation after clinical care was provided, and noting that the documentation inaccurately reflected the care was provided by the attending physician and not the resident. Due to concerns regarding unauthorized computer access, OIG shared this finding with the Chief of Staff immediately and with facility and VISN leaders during the on-site exit briefing.

Attending physicians reported an awareness that providing unauthorized access violated VA rules, but that they did so to avoid delaying scheduled patient care. Further, attending physicians expressed a perception that providing unauthorized access was known and permitted by facility leaders, though none could recall being directed by facility leaders to provide unauthorized access to residents.

Deputy chief of staff 2 told the OIG of awareness upon starting employment as an anesthesiologist at the facility in 2015 that residents had not had reliable access to VA computer systems on the first day of their clinical rotation. When residents lacked computer access, deputy

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[28] VHA Directive 1605.01, *Privacy and Release of Information*, July 24, 2023.

[29] VA Directive 6500, *VA Cybersecurity Program*, February 24, 2021.

[30] VA Information Security Rules of Behavior for Organizational Users.

[31] VHA Directive 1605.01.

[32] The OIG also interviewed attending surgeons and residents and an anesthesiologist who did not work in the operating room, and all denied providing or receiving unauthorized computer access.

chief of staff 2 described logging into the computer system and allowing resident access to facilitate supervised anesthesia care and associated documentation. Further, residents were previously able to resolve computer access barriers in one day, but in January 2023, resolution began to take longer and deputy chief of staff 2 reported this access issue to the facility education service.

In March 2023, deputy chief of staff 2 moved from the chief of anesthesiology and perioperative pain service (anesthesiology) role to an acting deputy chief of staff role. The new acting chief of anesthesiology told OIG that challenges with timely computer access for residents continued. Deputy chief of staff 2 reported learning "a few weeks" prior to OIG's on-site inspection that attending physicians were continuing to log residents into the computer system but were unable to remain in the operating room due to staffing limitations, and asked the new permanent chief of anesthesiology to stop the practice. Deputy chief of staff 2 denied instructing anesthesiologists in the operating room to provide unauthorized access to residents and an OIG review of electronic communication did not find evidence of instruction to attending physicians to provide residents with unauthorized access.

The associate chief of staff for education told OIG that, despite improvement efforts, residents routinely experienced barriers to accessing VA computers and computer programs at the beginning of VHA rotations and that resolution timeframes were variable.[33] Further, the associate chief of staff for education reported no awareness of residents documenting medical care under another clinician's name and stated that it "is not an acceptable workaround" when residents lack computer access. After learning from OIG that unauthorized computer access was being provided to residents, the associate chief of staff for education met with facility and affiliate stakeholders to review computer access requirements, requested support from the facility privacy officer to review compliance within the anesthesia service, and planned to continue work to reduce lapses in computer access for residents.

OIG also interviewed VISN and Office of Academic Affiliations (OAA) leaders who acknowledged resident computer access challenges exist at the VISN and national levels. Both VISN and OAA leaders reported that national information technology policy does not always adequately address individual facility resident onboarding processes. Consequently, residents may have difficulty obtaining computer access by the first day of a VA rotation. OAA leaders told OIG that concerns related to computer access requirements had been communicated to higher-level VHA leaders but no changes were made.

OIG found anesthesiology attending physicians provided unauthorized and unmonitored computer access to anesthesia residents to facilitate documentation of anesthesia care. This created an opportunity for unauthorized access to additional VA computer systems and may have resulted in an inaccurate record in the EHR of who provided care and treatment to a patient and

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[33] The associate chief of staff for education reported factors impacting authorized computer access at the start of a clinical rotation included trainees not returning information required to initiate computer access, communication being sent to an incorrect email address, user account deactivation due to lack of activity between VA rotations, delays with trainee onboarding, and unexpected access removal at the national level.

what elements of the care a resident provided. OIG learned attending physicians facilitated the unauthorized access due to a perception that facility leaders were aware and that the lack of resident access would delay patient care. OIG found unreliable computer access on the first day of a VHA rotation was not limited to the facility and was highlighted as a concern at both the VISN and national levels.

Conclusion

OIG substantiated the facility lacked infrastructure requirements for vascular and non-vascular interventional radiology, cardiac catheterization, and interventional neuroradiology. While the chief of surgery initiated waivers for these requirements, a lack of awareness of available services, unclear direction about waiver requirements, deficient communication of the waiver request status, and lack of VISN oversight led to delays in submission and approval of the waiver requests.

OIG did not substantiate the facility lacked Surgery Service coverage or qualified inpatient coverage as required for an *inpatient complex* facility.

While surgeons were not consistently completing required operative notes, Surgery Service and facility leaders took action to monitor and improve compliance with operative documentation completion as required by facility bylaws and Joint Commission standards. However, OIG identified a concern with the methodology used to monitor compliance, which placed the responsibility for ensuring completion of operative notes on PACU nurses without a retrospective audit to ensure that missing documentation is consistently captured.

OIG did not substantiate the allegation that routine patient privacy violations occurred in the surgical waiting area.

OIG substantiated facility leaders failed to ensure adherence to information security practices when anesthesiology attending physicians provided unauthorized VA computer access to anesthesiology residents practicing in operating rooms. While deputy chief of staff 2 was aware of the practice, OIG was unable to determine if deputy chief of staff 2 directed the unauthorized access. Unreliable computer access on the first day of a VHA rotation was a concern at both the VISN and national levels.

Recommendations

1. The Ann Arbor VA Medical Center Director ensures that service chiefs responsible for required invasive procedure infrastructure services ensure the completion of the annual review of infrastructure and that existing infrastructure is accurately reported.

2. The VA Healthcare System Serving Ohio, Indiana, and Michigan Network Director ensures that requirements and processes for invasive procedure complexity infrastructure waiver requests are clearly communicated to facility leaders.

3. The Under Secretary for Health ensures that guidance provided to Veterans Integrated Service Network and facility leaders regarding the invasive procedure complexity infrastructure waiver request process is clear and consistent with Veterans Health Administration Directive 1220(1).

4. The Ann Arbor VA Medical Center Director ensures that operative documentation is completed per facility policy, reviews the methodology for monitoring operative documentation compliance, and takes action as necessary.

5. The Ann Arbor VA Medical Center Director reviews and monitors staff and health professional trainee compliance with the rules of behavior as it applies to authorized access to all VA computer programs including clinical applications.

6. The Under Secretary for Health evaluates the process for granting authorized access to VA computer systems for health profession trainees and takes steps to ensure access is provided by the start of trainee rotations at VA facilities.