



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

August 14, 2013

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 No. DI-13-1868

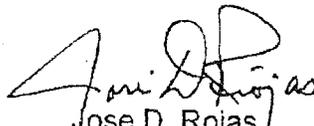
Dear Ms. Lerner:

I am responding to your letter regarding alleged violations raised by a whistleblower at the Central Alabama Veterans Health Care System, West Campus, Montgomery, Alabama (hereafter, the Medical Center). Mark Taylor, M.D., the whistleblower, alleged that by copying and pasting medical records, a physician has engaged in conduct that may constitute a violation of law, rule, or regulation, an abuse of authority, and a substantial and specific danger to public health. The Secretary has delegated to me the authority to sign this report and take any actions deemed necessary under 5 United States Code (U.S.C.) § 1213(d)(5).

The Secretary also asked the Under Secretary for Health to review this matter and to take any actions deemed necessary under 5 U.S.C. § 1213(d)(5). He, in turn, directed the Office of the Medical Inspector (OMI) to conduct an investigation. In its investigation, OMI did substantiate the first two of the three allegations made by the whistleblower, but could not substantiate the third, and made five recommendations for the facility. Findings from OMI's investigation are contained in the enclosed Final Report, which I am submitting for your review.

Thank you for the opportunity to respond.

Sincerely,


Jose D. Rojas
Chief of Staff

Enclosure

OFFICE OF THE MEDICAL INSPECTOR

Report to the
Office of Special Counsel
OSC File Number DI-13-1868

Department of Veterans Affairs
Central Alabama Veterans Health Care System
Montgomery, Alabama



Veterans Health Administration
Washington, DC

Report Date: July 12, 2013
TRIM 2013-D-595

Any information in this report that is the subject of the Privacy Act of 1974 and/or the Health Insurance Portability and Accountability Act of 1996 may only be disclosed as authorized by those statutes. Any unauthorized disclosure of confidential information is subject to the criminal penalty provisions of those statutes.

Executive Summary

Summary of Allegations

The Under Secretary for Health (USH) requested the Office of the Medical Inspector (OMI) investigate complaints lodged with the Office of Special Counsel (OSC) by Mark Taylor, M.D. (hereafter, the whistleblower) at the Central Alabama Veterans Health Care System (CAVHCS), West Campus, in Montgomery, Alabama (hereafter, the Medical Center). The whistleblower, who consented to the release of his name, served as the Chief of Surgery for 4 years. He alleges the Medical Center engaged in conduct that may constitute a violation of law, rule, or regulation, an abuse of authority, and a substantial and specific danger to public health due to the copying and pasting of medical records. OMI conducted a site visit to the Medical Center on May 6-7, 2013.

The whistleblower alleged:

1. A Staff Pulmonologist at the CAVHCS copied prior provider notes from patient medical records to reflect current readings, in violation of Department of Veterans Affairs (VA) Handbook and CAVHCS policy, likely resulting in inaccurate patient health information;
2. Information that is copied without proper attribution is a misrepresentation of health care data and may endanger patient health; and
3. Management was aware of this malfeasance but never took steps to refer this allegation to the appropriate reviewing authority.

Conclusions

OMI substantiated the allegation that a staff pulmonologist at the Medical Center copied prior provider notes from patient medical records to represent current readings, in violation of Veterans Health Administration (VHA) Handbook 1907.01, *Health Information Management and Health Records* and Medical Center Memorandum 136-11-26, *Copying, Pasting and Template Use in the Electronic Medical Record*, likely resulting in inaccurate patient health information.

- Dr. (b) (6) staff pulmonologist, actively engaged in prohibited copy and paste activities in at least six different Veterans' medical records, in violation of both VA and Medical Center policy.

- It is likely that these copying and pasting activities resulted in the documentation of inaccurate patient information, as the findings entered into the medical record included assessments and objective data that were not current.
- OMI is concerned that copying and pasting to this degree may rise to the level of falsification of a Government document and that if third party payers were billed for any of the pulmonologist's medical evaluations based on copied and pasted entries into the medical record, this could constitute fraud. These concerns were voiced to the Office of General Counsel (OGC) who referred them to the Office of Inspector General (OIG). OIG has asked VA to administratively address these issues, which VHA is in the process of doing.

OMI substantiated the allegation that copying without proper attribution is a misrepresentation of health care data, although OMI could not substantiate, at this time, whether it endangered patient health.

- OMI found no evidence of attribution of the copied and pasted information to the original writer, nor was the copied material assigned an original date.

OMI did not substantiate that management was aware of the malfeasance and did not take steps to refer the allegation to the appropriate authority. However:

- While the Associate Chief of Staff (ACOS) for Acute Care, Specialties, and Education did provide follow up and oversight of the ongoing professional practice evaluation (OPPE) and the focused professional practice evaluation (FPPE) process, there appears to be a lack of communication to leadership about the serious nature of the copying and pasting actions.
- The pulmonologist was removed from FPPE oversight based on his copying and pasting activities after 90 days, although there was continued evidence of some degree of copying and pasting.
- There was a lack of evidence in the Credentialing and Privileging Committee meeting minutes of the process created to monitor the copying and pasting activities of the pulmonologist until the issue was closed in April 2013.
- There was a lack of evidence in the Quality Leadership Board meeting minutes of any discussion of this specific copying and pasting problem.

Recommendations

The Medical Center should:

1. Broaden the scope of review for evidence of copying and pasting activities, to include all consults performed by Dr. (b) (6) in 2011 and 2012, and continue active oversight of the provider's clinical documentation for an extended period of time to ensure that a relapse does not occur; take appropriate administrative action based on the findings.
2. Conduct external peer reviews of the six medical records where serious copying and pasting occurred, with a focus on the determination of adverse outcomes or patient endangerment.
3. Provide clinical disclosure to each of the six Veterans where serious copying and pasting occurred.
4. Make an entry in the medical records where serious copying and pasting occurred, reflecting the entry of potentially inaccurate and non-current clinical information (see VHA Handbook 1907.01, page 25, paragraph 25(g)(2)(b), Administrative Correction).
5. Follow additional administrative review (pursuant to Recommendation 1) consult with the Office of Human Resources and OGC's Regional Counsel regarding the appropriate administrative action (see VHA Handbook 1907.01, page 23, paragraph 25(c)(3)(b)(2). In addition, after the additional administrative review, a decision should be made on the need to refer to OIG.

Summary Statement

OMI's investigation did not find violations or apparent violations of statutory laws or mandatory rules or regulations as set forth in the Code of Federal Regulations. OMI did find violation of VHA policy on copying and pasting (discussed in VHA Handbook 1907.01, page 22, paragraph 25.c). Additional administrative review regarding the appropriate administrative action has been recommended. In addition, further investigation has been recommended to determine whether the copying and pasting resulted in adverse patient outcomes or patient endangerment.

I. Introduction

The USH requested OMI investigate complaints lodged with OSC by Mark Taylor, M.D. (hereafter, the whistleblower) at the Central Alabama Veterans Health Care System (CAVHCS), West Campus, in Montgomery, Alabama (hereafter, the Medical Center). The whistleblower, who consented to the release of his name, served as the Chief of Surgery for 4 years. He alleges the Medical Center engaged in conduct that may constitute a violation of law, rule, or regulation, an abuse of authority, and a substantial and specific danger to public health due to the copying and pasting of medical records. OMI conducted a site visit to the Medical Center on May 6-7, 2013.

II. Facility Profile

The Medical Center is the West Campus of the two-division CAVHCS, which was formed in 1997 as a result of the merger of the Tuskegee and Montgomery VA Medical Centers. The two divisions serve 134,000 Veterans in 43 counties in Alabama and western Georgia. CAVHCS has 143 authorized hospital beds, 160 long-term care beds and a 43-bed homeless domiciliary. Health care services provided include primary, medical, surgical, mental health, and geriatrics and extended care, and a homeless program. In support of health education and residency programs, CAVHCS has affiliations with 24 schools, including Morehouse School of Medicine, Alabama State University, Auburn University, the University of Alabama, and Tuskegee University.

III. Allegations

1. A Staff Pulmonologist at the CAVHCS copied prior provider notes from patient medical records to reflect current readings, in violation of the VA Handbook and CAVHCS policy, likely resulting in inaccurate patient health information.
2. Information that is copied without proper attribution is a misrepresentation of health care data and may endanger patient health.
3. Management was aware of this malfeasance but never took steps to refer this allegation to the appropriate reviewing authority.

IV. Conduct of Investigation

An OMI team consisting of (b) (6) M.D., the Medical Inspector; (b) (6) M.D., Medical Investigator; and (b) (6) R.N., F.N.P., Clinical Program Manager, conducted the site visit. OMI reviewed relevant policies, procedures, reports, memorandums, and additional documents as listed in Attachment A. Entrance and exit briefings were held with Medical Center leadership. The whistleblower was interviewed by OMI via telephone on April 29, 2013 and again in person during the site visit.

OMI interviewed (b) (6) M.D., Ph.D., pulmonologist, by telephone on May 15 and May 17, 2013, since he was on leave during the OMI site visit.

(b) (6) M.D., cardiologist, was interviewed by telephone on May 8, 2013.

In addition, OMI interviewed the following individuals in person during the site visit:

- (b) (6) Director
- (b) (6) M.D., Chief of Staff
- (b) (6) M.D., Associate Chief of Staff (ACOS) for Acute Care, Specialties and Education
- (b) (6), Administrative Officer for Surgery
- (b) (6) Program Assistant for Surgery
- (b) (6) M.D., General Surgeon
- (b) (6) D.O., Anesthesiologist
- (b) (6) D.O., Chief of Anesthesiology
- (b) (6) M.D., Urologist

OGC reviewed OMI's findings to determine whether there was any violation of law, rule, or regulation.

OMI substantiated allegations when the facts and findings supported the alleged events or actions took place. OMI did not substantiate allegations when the facts showed the allegations were unfounded. OMI could not substantiate allegations when there was no conclusive evidence to either sustain or refute the allegation.

V. Findings, Conclusions, and Recommendations

Allegation 1

A Staff Pulmonologist at the CAVHCS copied prior provider notes from patient medical records to reflect current readings, in violation of the VA Handbook and CAVHCS policy, likely resulting in inaccurate patient health information.

Findings

In interviews with Dr. Taylor, the whistleblower, OMI learned that he discovered the issue of copying and pasting on the part of Dr. (b) (6) when the Chief Anesthesiologist, Dr. (b) (6) encountered a presurgical pulmonary assessment entered into the medical record by Dr. (b) (6) that was identical to a cardiac consultation note completed by Dr. (b) (6) 4 months earlier. This duplication included diagnoses, medications, review of systems, history, physical examination, and portions of the clinical evaluation. The duplication was verbatim, including sentence structure and punctuation.

Due to this discovery, as Chief of Surgery, Dr. Taylor reviewed ten medical records that included pulmonary consultations authored by Dr. (b) (6). He presented OMI with a list of six medical records where he alleged serious copying and pasting occurred. The OMI team reviewed the six records and found evidence of significant copying and pasting by Dr. (b) (6) that included the vital signs, physical examination, clinical assessment, and plan of care.

In each record, OMI found evidence of serious copying and pasting, reflecting duplication of some or all components of the patient visit including the chief complaint, specific physical examination findings, terminology used to describe vital signs, the review of systems, diagnoses, and plan of care. The copying and pasting often included the duplication of the note content, format, capitalization, sentence structure, slang, and spelling or typographical errors.

In one instance, Dr. (b) (6) was asked to complete a pulmonary consultation on a Veteran because of a "disordered respiratory pattern" and "haltering breathing." The Veteran had discontinued his inhaler and had been prescribed a continuous positive airway pressure (CPAP) machine.¹ When completing the consult, Dr. (b) (6) copied the objective findings from a primary care physician's note that had been completed 60 days prior. The primary care physician evaluated the Veteran's complaints that his "shoulders were jumping out of joint," that he had back pain, and was dropping things.

¹ CPAP is a treatment used by people with sleep apnea that uses mild to moderate air pressure to keep the airway open. <http://www.nhlbi.nih.gov/health/health-topics/topics/cpap/>

The primary care physician performed an upper extremity orthopedic exam of the Veteran's shoulders to measure his strength, the presence of tenderness, and upper extremity range of motion. In his pulmonary consult, Dr. (b) (6) copied the primary care physician's entire examination, verbatim, including the shoulder examination, with the same formatting, capitalization, and spelling errors. The example provided in Attachment B contains yellow highlighted sections representing the plagiarized information. The primary care assessment and plan were partially copied, and Dr. (b) (6) added to the plan, "follow up at CPAP." No attribution to the original primary care note was provided.

In a second case, OMI's review confirmed that Dr. (b) (6) copied and pasted the evaluation completed by a cardiologist 4 months earlier. The physical examination, as documented by Dr. (b) (6) included an exact replication of the entire cardiac assessment completed by Dr. (b) (6) with an identical description of the heart sounds and documentation of the same blood pressure, pulse, and personal discussion with the patient. Dr. (b) (6) partially copied the impression, as written by Dr. (b) (6) and added a discussion of the Veteran's risk for a procedure. There was no attribution of the original cardiology note completed by Dr. (b) (6). The example provided in Attachment C contains highlighted sections representing the plagiarized information. On interview, Dr. (b) (6) reported he was not aware that his note had been copied.

OMI reviewed VHA and Medical Center handbooks, policies, and directives applicable to copying and pasting in the electronic medical record. VHA Handbook 1907.01, *Health Information Management and Health Records*, specifically directs that, "Plagiarized data, without attribution, in the patient record is prohibited."

Medical Center Memorandum 136-11-26, *Copying, Pasting and Template Use in the Electronic Medical Record*, states that it is the policy, "...to refrain from cutting, copying and pasting information from other documents into progress notes except in situations whereby it is critical that the data be repeated and has a direct impact on patient care." The memorandum goes on to say that, "If information is cut, copied and pasted then the author must credit any information obtained from another clinician's work. This credit must include the author of the information and the date originally written."

OMI conducted telephone interviews with Dr. (b) (6) on May 15 and again on May 17, 2013. Dr. (b) (6) admitted to copying and pasting historical information, vital signs, examinations, assessments, and plans of other clinicians, but reported he wished to include this information within his own assessment and plan of care. He acknowledged, in his words, that his "technical incompetence" and "stupidity" resulted in the inclusion of other's information in his signed notes. He reported that he conducted his own physical examinations, although OMI could not locate separate findings for the information he gathered. He was not able to recall how long he has engaged in copying and pasting, but states that he has changed his behavior. A review of the documents included in the remedial actions taken by the Medical Center to provide oversight of

Dr. (b) (6) copying and pasting activities revealed that he engaged in this activity, to some degree, as recently as March 2013. The ACOS suggested the use of a pulmonary note template to assist Dr. (b) (6) in his efforts to improve his clinical documentation skills.

Conclusions

OMI substantiated the allegation that a staff pulmonologist at the Medical Center copied prior provider notes from patient medical records to represent current readings, in violation of VHA Handbook 1907.01, *Health Information Management and Health Records*, and Medical Center Memorandum 136-11-26, *Copying, Pasting and Template Use in the Electronic Medical Record*, likely resulting in inaccurate patient health information.

- Dr. (b) (6) staff pulmonologist, actively engaged in prohibited copying and pasting activities in at least six different Veterans' medical records, in violation of both VHA and Medical Center policy.
- It is likely that these copying and pasting activities resulted in the documentation of inaccurate patient information, as the findings entered into the medical record included assessments and objective data that were not current.
- OMI is concerned that copying and pasting to this degree may rise to the level of falsification of a Government document, and that if third party payers were billed for any of the pulmonologist's medical evaluations (based on copied and pasted entries into the medical record), this could constitute fraud. These concerns were voiced to OGC who referred them to OIG. OIG has asked VA to administratively address these issues, which VHA is in the process of doing.

Recommendations

The Medical Center should:

1. Broaden the scope of review for evidence of copying and pasting activities, to include all consults performed by Dr. (b) (6) in 2011 and 2012, and continue active oversight of the provider's clinical documentation for an extended period of time to ensure that a relapse does not occur; take appropriate action based on the findings.

Allegation 2

Information that is copied without proper attribution is a misrepresentation of health care data and may endanger patient health.

Findings

The OMI's review of six medical records revealed that Dr. (b) (6) copied and pasted notes written by other providers that were dated up to 6 months prior to the Veteran's visit with him. Additionally, Dr. (b) (6) copied and pasted, in several cases, many components of the medical record, (e.g., chief complaint, history, physical examination, vital signs, and plan of care, originally composed by physicians and mid-level providers in primary care, nephrology, and cardiology. OMI found no evidence of attribution by Dr. (b) (6) to any of the original authors. At this time, it is unclear whether entry of non-current and possibly inaccurate physical assessments and vital signs adversely affected any patient outcomes or endangered patient health. OMI has no evidence of adverse clinical events resulting from these copying and pasting activities.

VHA policy states that "Clinical, ethical, financial, and legal problems may result when text is copied in a manner that implies the author or someone else obtained historical information, performed an exam, or documented a plan of care, when the author or someone else did not personally collect the information at the time the visit is documented."²

Conclusions

OMI substantiates the allegation that copying and pasting without proper attribution is a misrepresentation of health care data, although OMI could not substantiate, at this time, whether it endangered patient health.

- OMI found no evidence of attribution of the copied and pasted information to the original writer, nor was the copied material assigned an original date.

Recommendations

The Medical Center should:

1. Conduct external peer reviews of the six medical records where serious copying and pasting occurred, with a focus on the determination of adverse outcomes or patient endangerment.

² VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012, 25c. *Copy and Paste, "Cloned Notes," Imported Text, Objects, etc.* (p. 22).

2. Provide clinical disclosure to each of these six Veterans where serious copying and pasting occurred.
3. Make an entry in the medical records where serious copying and pasting occurred, reflecting the entry of potentially inaccurate and non-current clinical information (see VHA Handbook 1907.01, page 25, paragraph 25(g)(2)(b), Administrative Correction).

Allegation 3

Management was aware of this malfeasance but never took steps to refer this allegation to the appropriate reviewing authority.

Findings

Dr. (b) (6) immediate supervisor to Dr. (b) (6) reported that he received notification of the pulmonologist's alleged copying and pasting problem on October 12, 2012. Dr. (b) (6) stated he spoke to the Chief of Staff about this matter, although the Chief of Staff told OMI that he was not aware of the extent of the problem. A counseling letter, identifying a significant copying and pasting problem, was prepared, discussed, and signed by both Dr. (b) (6) and Dr. (b) (6) on October 30, 2012. This letter warned Dr. (b) (6) that copying and pasting was prohibited and would not be tolerated; however, the letter was not considered disciplinary, and it was not placed in the provider's official personnel folder. The counseling letter informed Dr. (b) (6) that his medical record documentation practices would be monitored by routine review and carried out under the ongoing professional practice evaluation (OPPE), a process conducted on all clinical providers.

In November 2012, a routine OPPE review by a peer provider of ten of Dr. (b) (6) records contained a recommendation for the "need to follow copy and paste guidelines," although there was no annotation of the specific copying and pasting problems with each record. On January 3, 2013, due to continued evidence of copying and pasting in the medical record, Dr. (b) (6) was placed on a focused professional practice evaluation (FPPE) through March 2, 2013. In the minutes of the meetings during this time of both the Credentialing and Privileging Committee and the Medical Staff Quality Leadership Board, there was no evidence that these problems had been addressed.

From January to March 2013, the Medical Center conducted the following reviews to ascertain the extent of the problem:

- A chart review, in January 2013, revealed copying and pasting activity in six of ten records.

- An additional review of five medical records on January 11, 2013, was notable for its failure to complete the boxes indicating compliance or non-compliance with copying and pasting.
- Yet another review of five medical records, between January 9 and March 28, 2013, indicated compliance with prohibited copying and pasting practices in only a single instance.

On February 20, 2013, an FPPE note written by Dr. (b) (6) stated that Dr. (b) (6) was now using a progress note template and was no longer copying and pasting. An ongoing competency assessment for Dr. (b) (6) signed by Dr. (b) (6) on April 3, 2013, indicated a fully satisfactory performance with no concerns, but with one written comment, "Avoid copy and paste." On April 3, 2013, Dr. (b) (6) was removed from the FPPE by Dr. (b) (6) with a satisfactory performance. The date of April 12, 2013, is entered into the Credentialing and Privileging FPPE tracking report for Dr. (b) (6) removal from the FPPE process.

Medical Center Memorandum 136-11-09, *Medical Record Management and Documentation*, directs that the Chief of Staff, with the Executive Committee of the Medical Staff (now the Medical Staff Quality Leadership Board) and service line chiefs, maintain responsibility for clinical documentation and requirements. OMI determined that while Dr. (b) (6) informed the Chief of Staff about the copying and pasting problem, there is no evidence that the Chief of Staff was involved in the resolution process. The same Medical Center policy also states that when copying and pasting violations occur, they should be reported to the ACOS, the Compliance and Business Officer, and the Chief of Staff. "Failure to comply with these standards may be deemed a violation of *The Privacy Act of 1974* and *Standards of Ethical Conduct for Employees of the Executive Branch* (5 CFR Part 2635). Disciplinary action may be taken if deemed appropriate."³ Disciplinary action is also discussed in VHA Handbook 1907.01, paragraph 25 c (3)(b)(3).

A review of the Medical Staff meeting minutes indicates that, on a monthly basis, there is a reminder about the Medical Center's policy prohibiting copying and pasting.

Conclusions

OMI did not substantiate that management was aware of the malfeasance and did not take steps to refer the allegation to the appropriate authority. However:

³ *The Privacy Act of 1974*, (5 USC § 552a), retrieved from <http://www.justice.gov/opcl/privstat.htm>. Title 5 Code of Federal Regulations (CFR) Part 2635, *Standards of Ethical Conduct for Employees of the Executive Branch*, retrieved from <http://www.oge.gov/Laws-and-Regulations/OGE-Regulations/5-C-F-R--Part-2635---Standards-of-ethical-conduct-for-employees-of-the-executive-branch/>.

- While the ACOS did provide follow up and oversight of the OPPE and FPPE process, there appears to be a lack of communication with leadership about the serious nature of copying and pasting actions and incomplete reporting, as required by policy.
- The pulmonologist was removed from FPPE oversight regarding his copy and paste activities after 90 days, although there was continued evidence of some degree of copying and pasting.
- OMI could find no evidence in the minutes of the Quality Leadership Board of the Credentialing and Privileging Committee that this problem had been discussed, until April 12, 2013, when it recommended that Dr. (b) (6) be removed from FPPE.
- There was a lack of evidence in the Quality Leadership Board meeting minutes of any discussion of this specific copying and pasting problem.

Recommendations

The Medical Center should:

1. Following additional administrative review (pursuant to Recommendation 1), consult with the Office of Human Resources and OGC's Regional Counsel regarding the appropriate administrative action (see VHA Handbook 1907.01, page 23, paragraph 25(c)(3)(b)(2)). In addition, after the additional administrative review, a decision should be made on the need to refer to OIG.

Attachment A

Documents Reviewed by OMI

1. Veterans Health Administration (VHA) Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
2. CAVHCS Memorandum No. 136-11-26, *Copying, Pasting and Template Use in the Electronic Medical Record*, May 31, 2011.
3. CAVHCS, *Bylaws of the Medical Staff of the Central Alabama Veterans Health Care System*, June 15, 2012.
4. CAVHCS Memorandum No. 136-11-09, *Medical Record Management and Documentation*, May 31, 2011.
5. CAVHCS, *Rules of the Medical Staff*, 2011.
6. Title 5 Code of Federal Regulations Part 2635, *Standards of Ethical Conduct for Employees of the Executive Branch*.
7. Selected patient electronic medical records.
8. Various electronic and paper communications, meeting minutes, and performance documents.

Attachment B

The highlighted sections represent plagiarized information.

LOCAL TITLE: PULMONARY
CONSULT
STANDARD TITLE: PULMONARY
CONSULT

DATE OF NOTE: (b) (6)
AUTHOR: (b) (6)

ENTRY DATE: (b) (6)
EXP

COSIGNER:

INSTITUTION:

DIVISION:

URGENCY:
COMPLETED

STATUS:

(b) (6) WAS REFERRED WITH THE FOLLOWING NOTE:--

REASON FOR CONSULT (Briefly state symptoms):
disordered reapiatory pattern, patient with bilateral tonsilar
enlargement,
describes haltering breathing, discontinued inhaler, low loop noted
patient has ENT appointment for evaluation of tonsils - has CPAP..

vital signs / nursing notes noted
patient walking with cane
tonsillar enlargement
Chest Clear
Cv rrr, no gallops, no murmus
neck neg
shoulder no point tenderness, ROM intacts biceps/ticeps intact
muscle strength good, no decreased grip
review of PET's
keloid formation postrior right back

A/P

Sleep apnea
tonsillar enlargement - to ENT
Multiarticular joint pain and arthritis

plan: follow up at cpap

Clinical Reminder(s)/

C-Medication Reconciliation:

BADR - Brief Adv React/All

Allergy/Reaction: No Known Allergies

RART - Remote Allergy/ADR

No Remote Allergy/ADR Data available for this patient

PS02 - Recent Rx Profile

Allergies: NKA,
Adverse Reactions:

Active and Recently Expired Outpatient Medications
(including Supplies):

Active Outpatient Medications	Status
1) ALBUTEROL 90MCG (CFC-F) 200D ORAL INHL INHALE 2 PUFFS BY MOUTH EVERY 4 HOURS AS NEEDED FOR BREATHING (SHAKE WELL BEFORE USING)	ACTIVE
2) ARTIFICIAL TEARS POLYVINYL ALCOHOL INSTILL 1 DROP IN BOTH EYES FOUR TIMES A DAY AS NEEDED FOR DRY EYES	ACTIVE
3) BUPROPION HCL 75MG TAB TAKE TWO TABLETS BY MOUTH EVERY MORNING FOR NERVES	ACTIVE
4) CYCLOBENZAPRINE HCL 10MG TAB TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR MUSCLE RELAXATION	ACTIVE
5) DOXEPIN HCL 150MG CAP TAKE ONE CAPSULE BY MOUTH AT BEDTIME FOR NERVES	ACTIVE (S)
6) FLUNISOLIDE 0.025% 200D NASAL INH SPRAY INHALE 2 SPRAYS EACH NOSTRIL TWICE A DAY FOR SEASONAL ALLERGIES	ACTIVE
7) HYDROCHLOROTHIAZIDE 25MG TAB TAKE ONE TABLET BY MOUTH EVERY MORNING FOR BLOOD PRESSURE	ACTIVE
8) HYDROCODONE 10/ACETAMINOPHEN 50 OMG TAB TAKE 1 TABLET BY MOUTH TWO TIMES A DAY AS NEEDED FOR PAIN.	ACTIVE (S)
9) HYDROXYZINE HCL 25MG TAB TAKE ONE TABLET BY MOUTH TWICE A DAY FOR ITCHING	ACTIVE
10) LISINOPRIL 40MG TAB TAKE ONE TABLET BY MOUTH EVERY DAY FOR BLOOD PRESSURE	ACTIVE
11) MELOXICAM 15MG TAB TAKE ONE TABLET BY MOUTH EVERY DAY WITH FOOD FOR PAIN & INFLAMMATION	ACTIVE
12) SILDENAFIL CITRATE 100MG TAB TAKE ONE TABLET BY MOUTH AS NEEDED 1 HOUR PRIOR TO SEXUAL ACTIVITY FOR ERECTILE DYSFUNCTION (DO NOT EXCEED ONE DOSE IN 24 HR PERIOD)	ACTIVE
13) SIMVASTATIN 40MG TAB TAKE ONE TABLET BY MOUTH EVERY EVENING FOR CHOLESTEROL	ACTIVE

Inactive Outpatient Medications

Status

1) ALBUTEROL S04 0.083% INHL 3ML INHALE CONTENTS OF 1 AMPULE IN NEBULIZER BY MOUTH	EXPIRED
--	---------

ONCE TO BE ADMINISTERED IN
CLINIC DURING PFT TEST.

- 2) SODIUM CHLORIDE 0.9% INHL 3ML INHALE CONTENT OF 1 EXPIRED
VIAL IN NEBULIZER BY MOUTH ONCE USE TO
MIX WITH ALBUTEROL TO GIVE NEBULIZER TX
WHEN PFT TEST PERFORMED

15 Total Medications

RDIM - Remote Active Meds

No Active Remote Medications for this patient
Allergies reviewed with patient/caregiver. (Information updated as
appropriate)

N/A (No new allergies reported) Active, Remote and Non VA
medications appearing on the Med Chart were reviewed with
patient/caregiver. (Note: Order checks for new Non VA
medications must be
reviewed) Yes

Were medication discrepancies identified?

No, there were no discrepancies

Were medication changes made (added/deleted/modified)
during the visit?

No, there were no medication changes made

Was the patient transferred to an alternate level of care
(i.e. transferred or admitted to hospital)?

No, patient was not transferred to an alternate level of
care (no additional actions are required).

/es/ (b) (6) MD, PhD

(H.Adm) PULMONOLOGY/SLEEP

MEDICINE

Signed: (b) (6)

CLIN DOC: Progress Note

System

Division:

Attachment C

The highlighted sections represent plagiarized information.

LOCAL TITLE: PULMONARY
CONSULT
STANDARD TITLE: PULMONARY
CONSULT

DATE OF NOTE: (b) (6) ENTRY DATE: (b) (6)
AUTHOR: (b) (6) EXP
COSIGNER:
INSTITUTION:
DIVISION: [REDACTED]
URGENCY: STATUS:
COMPLETED

[REDACTED] WAS REFERRED WITH THE FOLLOWING NOTE;--

REASON FOR CONSULT (Briefly state symptoms): pulmonary clearance for colonoscopy.pft done "

The patient is a [REDACTED]-year-old lady :--
Her history of ischemic disease dates back to 1996 or 1998 when she had chest pain and may have had an myocardial infarction (per her husband). In any event, she underwent bypass surgery at Baptist South. She had a followup catheterization on (b) (6) which showed severe native coronary disease, but all of her grafts, including the left internal mammary artery to the left anterior descending were patent. Left ventricular function at that time was normal and no scar was apparent. She has done well since then. She has had no cardiac symptoms of any type. She has had no angina or failure or dysrhythmia symptoms. She has had no chest pain, edema, syncope, palpitations, paroxysmal nocturnal dyspnea, orthopnea, et cetera.

ALLERGIES: NONE.

EXERCISE: She does not do any regular exercise. However, she does housework. She has no chest pain or undue shortness of breath with this activity.

HABITS: She smokes a half pack per day and we talked about cessation at length. She does not drink.

SURGERIES: Coronary artery bypass graft, tonsillectomy.

ALTERNATIVE/OVER-THE-COUNTER MEDICINES AND SUBSTANCES: None.

SLEEP HISTORY: Not suggestive.

FAMILY HISTORY: Mother had some type of chronic problem, but the patient cannot recall well.

VACCINATIONS: She is current on influenza on Pneumovax.

SYSTEM REVIEW: No seizures, strokes, head trauma, psychiatric problems, unusual headaches. Progressive memory problems as noted. Vision, she states she needs new glasses. No problems with nose or throat. No thyroid problems per system review, though I note she is on replacement (and her TSHs are still high). No glucose intolerance. No breast problems or adenopathy. No cough, hemoptysis, pneumonia, wheezing, asthma, tuberculosis. No bleeding or clotting problems. No hematemesis, melena, ulcers, hepatitis, pancreatitis, fever, weight loss, change in bowel habits. Positive stool guaiacs. However, her husband says that this is from hemorrhoids and that this stopped when she began to use Preparation H. No abnormal vaginal bleeding. No problem with urination or kidney stones or hematuria. No blood or skin or bone problems other than degenerative joint disease, osteoporosis. No phlebitis or claudication.

PHYSICAL EXAMINATION:

GENERAL: This is a ■-year-old lady looking older than her stated age. She is very pleasant and continues to tell me that she has problems remembering things.

VITAL SIGNS: Blood pressure 153/71 and pulse is 46 and regular.

NECK: No increased jugular venous pressure. The carotids are normal. There is no bruit. Thyroid is not enlarged.

CHEST: Clear. She does have increased AP diameter and very significant prolongation on even normal expiration. There is no wheezing.

HEART: No lift. Rhythm is regular. The heart sounds are normal. There is a faint systolic ejection murmur at the base and apex. No diastolic murmur or S3.

ABDOMEN: Soft, but she has mild tenderness on palpation of her epigastrium and there is a question of aortic enlargement.

EXTREMITIES: Show no edema, cord or calf pain. Her pulses are intact though diminished. No femoral bruit.

NEUROLOGICAL/PSYCHIATRIC: She is alert and oriented but, again, has obvious problems with her memory. Nonfocal.

LABORATORY: EKG on May 4 shows sinus bradycardia. Otherwise, unremarkable.

May 7 chest x-ray is negative.

IMPRESSION: The patient is in need of colonoscopy. She is at mild increased risk on the basis of her ischemic disease.

We have ordered an ultrasound of her abdominal aorta because of the epigastric tenderness and the question of a slight enlargement.

We talked about smoking cessation at length. We talked about diet and activity and heat avoidance. SHE is resistant to idea of quitting cigaretts.

DIAGNOSES:

1. Ischemic heart disease.
2. Dementia.
3. Chronic obstructive pulmonary disease.
4. Osteoporosis.
5. Dyslipidemia.
6. TOBACCO USE DISORDER

MEDICATIONS: Medications are listed as

1. Alendronate.
2. Aspirin.
3. Atenolol.
4. Benazepril.
5. Hydrochlorothiazide.
6. Levothyroxine.
7. Meclizine.
8. Meloxicam.
9. Nitroglycerin.
10. Simvastatin.

PFTS REVIEWED

discussion:-- She has significant risk factors:- 1) AGE.
2) SMOKING.
3) ISCHAEMIC HEART DISEASE.
4) AORTIC ANEURYM.

SHE IS OF HIGH RISK FOR ANY PROCEEDURE LEAVE ALONE COLONOSCOPY. I AM UNABALE TO CLEAR 10 0%.

Clinical Reminder(s)/

C-Medication Reconciliation:

BADR - Brief Adv React/All

Allergy/Reaction: No Known Allergies

RART - Remote Allergy/ADR

No Remote Allergy/ADR Data available for this patient

PS02 - Recent Rx Profile

Allergies: NKA,

Adverse Reactions:

Active and Recently Expired Outpatient Medications
(including Supplies):

Active Outpatient Medications	Status
1) ALENDRONATE 7 0MG TAB TAKE ONE TABLET BY MOUTH ONCE PER WEEK (EVERY 7 DAYS) FOR BONES ON 1ST ARISING (AND AT LEAST 3 0 MINUTES BEFORE EATING) WITH FULL GLASS OF PLAIN WATER. REMAIN UPRIGHT (DO NOT LIE DOWN) FOR AT LEAST 3 0 MINUTES	ACTIVE
2) ASPIRIN 81MG EC TAB TAKE ONE TABLET BY MOUTH EVERY DAY FOR HEART PROTECTION	ACTIVE
3) ATENOLOL 100MG TAB TAKE ONE TABLET BY MOUTH EVERY DAY ON AN EMPTY STOMACH FOR BLOOD PRESSURE	ACTIVE
4) HEMORRHOIDAL RTL OINT APPLY SMALL AMOUNT IN RECTUM TWICE A DAY AS NEEDED FOR HEMORRHOIDS	ACTIVE
5) HYDROCHLOROTHIAZIDE 25MG TAB TAKE ONE TABLET BY MOUTH EVERY MORNING FOR BLOOD PRESSURE	ACTIVE
6) LEVOTHYROXINE NA (SYNTHROID) 0.05MG TAB TAKE ONE TABLET BY MOUTH BEFORE BREAKFAST ON EMPTY STOMACH FOR THYROID	ACTIVE
7) MECLIZINE HCL 25MG TAB TAKE ONE TABLET BY MOUTH THREE TIMES A DAY FOR DIZZINESS	ACTIVE
8) MELOXICAM 7.5MG TAB TAKE ONE TABLET BY MOUTH EVERY DAY WITH FOOD FOR PAIN & INFLAMMATION	ACTIVE
9) NITROGLYCERIN 0.4MG SL TAB DISSOLVE ONE TABLET UNDER THE TONGUE EVERY DAY AS NEEDED USE 3 DOSES TAKEN 5 MINUTES APART AS NEEDED. CALL 911 IF CHEST PAIN IS UNCHANGED OR WORSENS 5 MINUTES AFTER 1ST DOSE	ACTIVE
10) SIMVASTATIN 40MG TAB TAKE ONE TABLET BY MOUTH EVERY EVENING FOR CHOLESTEROL	ACTIVE (S)

Inactive Outpatient Medications
Status

1) DONEPEZIL HCL 10MG TAB TAKE ONE TABLET BY MOUTH AT BEDTIME FOR MEMQRY	EXPIRED
2) DONEPEZIL HCL 5MG TAB TAKE ONE TABLET BY MOUTH AT BEDTIME FOR MEMORY	EXPIRED

12 Total Medications

RDIM

Remote Active Meds

No Active Remote Medications for this patient
Allergies reviewed with patient/caregiver. (Information updated as appropriate)

N/A (No new allergies reported) Active, Remote and Non VA medications appearing on the Med Chart were reviewed with patient/caregiver. (Note: Order checks for new Non VA medications must be reviewed)

Yes

Were medication discrepancies identified?

No, there were no discrepancies

Were medication changes made (added/deleted/modified) during the visit?

No, there were no medication changes made

Was the patient transferred to an alternate level of care (i.e. transferred or admitted to hospital)?

No, patient was not transferred to an alternate level of care (no additional actions are required).

/es/ (b) (6) MD, PhD (H.Adm) PULMONOLOGY/SLEEP MEDICINE Signed:

(b) (6)

CLIN DOC: Progress Note

System

Division: