DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

OCT 07 2014

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:

In response to a request from the Office of Special Counsel referencing VA's July 12, 2013, report on a whistleblower's allegations at the Central Alabama Veterans Health Care System, West Campus, Montgomery, Alabama, I am providing you with the requested information. This supplemental information clarifies a March 27, 2014, addendum to the report, describing the health care system's progress on report recommendations. It also provides information about personnel actions taken against Dr. Sundaram, a physician who copied and pasted medical records, and describes administrative processes related to disciplining physicians. We have addressed each question in the accompanying document.

Thank you for the opportunity to respond to your inquiry.

Sincerely,

Jose D. Riojas
Chief of Staff

Enclosure

Veterans Health Administration
Clarifications on Supplemental Report
to the
Office of Special Counsel:
Central Alabama Veterans Health Care System,
Montgomery, Alabama.
OSC File No. DI-13-1868
July 28, 2014

BACKGROUND

In response to a request from the Office of Special Counsel (OSC), the Veterans Health Administration's (VHA) Office of the Medical Inspector (OMI) provides the following information:

OSC QUESTIONS AND VHA's RESPONSES

1. **Question:** Outlining the actions taken to address the additional 1,241 instances of improper copying and pasting, what did the facility do in response to this finding, i.e., continued FPPE, or other action?

Response: Dr. Sundaram was placed under a Focused Professional Practice Evaluation (FPPE) from January 3 through April 4, 2013. During this period there were no additional copy and paste incidents. Thereafter, management continued to monitor his practice closely via an Ongoing Professional Practice Evaluation (OPPE) which entailed monthly record reviews. On the occasion of one such review, two additional incidents where Dr. Sundaram had copied and pasted clinical information (including vital signs and parts of the patients' past medical history) in July 2013 were discovered. The treatment that Dr. Sundaram had prescribed in these two cases was appropriate as evidenced in his chart documentation.

The Medical Center's Chief of Staff, and Quality Management Office conducted a review of 10 percent of the 1,241 instances of copy and paste identified to determine whether there were any adverse events related to the care and quality of care provided. The criteria used to determine whether a patient had experienced an adverse outcome included: readmission to the hospital, unscheduled medical appointment, emergency department visit for a pulmonary-related condition within 30 days, or death.

Based on its review, the Medical Center determined that there were no negative impacts in the care provided to the patients as a result of Dr. Sundaram's copy and paste practices. Dr. Sundaram received a formal reprimand in accordance with agency human resources policy. He subsequently retired from the Department of Veterans Affairs on July 18, 2014.

2. **Question:** Provide the definition of a 'Focused Professional Practice Evaluation' (FPPE).

Response: Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) are nationally-accepted procedures mandated by The Joint Commission (JC) for hospital accreditation. The relevant standards are:

- JC Standard MS.08.01.01, which states, "The organized medical staff defines the circumstances requiring monitoring and evaluation of a practitioner's professional performance." This standard defines "Focused Professional Practice" as a process whereby the organization evaluates the privilege-specific competence of any practitioner where evidence that the practitioner is competent to performing the requested privilege(s) at the organization is not documented. FPPE may also be used when a question arises regarding a practitioner's ability to provide safe, high-quality patient care when privileges have already been granted. FPPE is a time-limited period during which the organization evaluates and determines the practitioner's professional performance.

- JC Standard HR.02.01.03, which states, "Before assigning renewed or revised clinical responsibilities to staff who are permitted by law and the organization to practice independently, the following occurs: the organization reviews any clinical performance in the organization that is outside acceptable standards.

VHA's definition of FPPE complies with the JC standards and is found in VHA Handbook 1100.19 of October 15, 2012. According to the Handbook, FPPE is not a restriction or limitation on the practitioner's ability to practice independently, but rather an oversight process employed by the facility when the practitioner cannot provide documented evidence of competence to perform the privileges requested. The Handbook further states:

1. The FPPE is "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance."

2. The FPPE typically occurs "at the time of initial appointment to the medical staff, or when the granting of new, additional privileges. The focused professional practice evaluation may be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high-quality patient care."

3. The criteria for the FPPE process "are to be defined in advance, using objective criteria accepted by the practitioner, recommended by the Service Chief and Executive Committee of the Medical Staff as part of the privileging process, and approved by the Director. The process may include periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients. **NOTE:** *Failure of a practitioner to accept the criteria for the FPPE will result in new privileges not*

being granted or additional actions taken as appropriate, for currently privileged practitioners".

4. "Results of the FPPE must be documented in the practitioner's provider profile and reported to the Executive Committee of the Medical Staff."

3. **Question:** In the 1,241 instances of improper copying and pasting incidents, what was the determination regarding whether there were any adverse patient events?

Response: The medical staff at the facility, with oversight by the Chief of Staff and the Quality Management Office, reviewed a 10 percent sample of the 1,241 instances to determine whether any adverse events had occurred. In these reviews, the medical staff evaluated the documented assessments, treatments, and arrangements for follow-up care in each sample case. The criteria used to determine whether a patient had experienced an adverse outcome included: hospital readmissions, unscheduled medical appointments, emergency department visits within 30 days for a pulmonary-related condition, or death. Based on its review, the Medical Center determined that there were no negative impacts in the care provided to the patients as a result of Dr. Sundaram's copy and paste practices.

In addition, six peer reviews conducted by two contract pulmonologists who were not on staff at the Medical Center found no adverse patient outcomes by applying the standards of clinical care for pulmonary medicine.

4. **Question:** What were the results of Dr. Sundaram's FPPE in 2013?

Response: Dr. Sundaram was placed on an FPPE from January 3 through April 4, 2013. Since he demonstrated full compliance with the copy and paste policy during this period, the Medical Center determined that he had successfully completed the FPPE and that his clinical documentation was appropriate. He was then placed on an OPPE, which included reviews of 10 of Dr. Sundaram's electronic medical record notes per month over 12 months. In July 2013, during this concurrent review process, 2 of the 10 records reviewed by his superiors were found to have involved copying and pasting of information from another patient's record. Dr. Sundaram received a formal reprimand in accordance with agency human resources policy.

5. **Question:** Does he remain working as a physician at the VA?

Response: No. Dr. Sundaram retired from the Medical Center on July 18, 2014.

6. **Question**: Has there been additional disciplinary action taken as a result of the FPPE?

Response: During the FPPE period of January 3 through April 4, 2013, there were no disciplinary actions taken. As noted above, FPPE is not a disciplinary or adverse privileging action; rather it is a method for determining clinical competency in cases

where there is reason to believe that a practitioner may not be competent to perform specific privileges.

As a result of the ongoing review of his medical record consults, it was discovered in July 2013 that Dr. Sundaram had again copied and pasted other Veterans' past medical histories and vital signs into his electronic medical record notations in 2 of 10 cases reviewed after the FPPE was completed. After consultation with the Department of Human Resources and the Veterans Integrated Service Network 16's Regional Counsel, the agency issues a written reprimand in accordance with agency policy.