



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

July 8, 2015

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File Nos. DI-14-3650 & DI-13-4570

Dear Ms. Lerner:

I am responding to your letter regarding allegations made by two whistleblowers at the James E. Van Zandt Veterans Affairs (VA) Medical Center, (hereafter, the Medical Center) in Altoona, Pennsylvania. The whistleblowers alleged that a practitioner in Physical Medicine and Rehabilitation Service is neurologically impaired and incompetent to practice. The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary as referenced in 5 United States Code § 1213(d)(5).

The Secretary asked that the Interim Under Secretary for Health refer the whistleblowers' allegations to the Office of the Medical Inspector who assembled and led a VA team on two site visits to the Medical Center February 9-11 and 17-18, 2015. VA did not substantiate either of the whistleblower's two allegations.

VA made nine recommendations for the Medical Center to improve training and provider practices. Findings from the investigation are contained in the report, which I am submitting for your review.

Thank you for the opportunity to respond.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert L. Nabors II". The signature is stylized and includes a large circular flourish at the end.

Robert L. Nabors II
Chief of Staff

Enclosure

**DEPARTMENT OF VETERANS AFFAIRS
Washington, DC**

**Report to the
Office of Special Counsel
OSC File Numbers DI-14-3650 & DI-13-4570**

**James E. Van Zandt Veterans Affairs Medical Center
Altoona, Pennsylvania**



Report Date: May 11, 2015

TRIM 2015-D-26

Executive Summary

The Interim Under Secretary for Health (I/USH) requested that the Office of the Medical Inspector (OMI) assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the James E. Van Zandt VA Medical Center (hereafter, the Medical Center), Physical Medicine and Rehabilitation Service (PM&RS), Altoona, Pennsylvania.

James DeNofrio, PM&RS Administrative Officer, and Timothy Skarada, Physical and Occupational Therapy (P&OT) Supervisor, both of whom consented to the release of their names, alleged that employees are engaging in conduct that may constitute violations of laws, rules or regulations, and gross mismanagement, which may lead to a substantial and specific danger to public health. The VA team conducted a site visit to the Medical Center on February 9–11, 2015, and completed the second half of the investigation on February 17–18, 2015.

Specific Allegations of the Whistleblowers

1. (b) (6) PM&RS chief, appears to be neurologically impaired and incompetent, yet continues to treat patients; and
2. Altoona VAMC officials have failed to respond to the continuing concerns regarding (b) (6)' impairment and incompetency.

VA **substantiated allegations** when the facts and findings supported that the alleged events or actions took place and **did not substantiate allegations** when the facts and findings showed the allegations were unfounded. VA was **not able to substantiate allegations** when the available evidence was not sufficient to support conclusions with reasonable certainty about whether the alleged event or action took place.

After careful review of findings, VA makes the following conclusions and recommendations.

Conclusions for Allegation 1

VA **did not substantiate** that (b) (6) is neurologically impaired and incompetent. He underwent thorough, independent neurological and neuropsychological evaluations in (b) (6) 2013, the results of which indicated no evidence of impairment at that time. Some (but not all) witnesses described occasional incidents of forgetfulness, slight confusion, or questionable judgment since then. (b) (6) failed to communicate his findings and recommendations for treatment to the referring provider in at least three instances, while in other cases his documentation of consultation findings did not address the main reason for the consultation. He underwent a general medicine and neurological evaluation in (b) (6) 2015, the results of which also indicated no evidence of impairment. Since his evaluations revealed no evidence of impairment, some of the issues identified would be considered

noncompliance with accepted physician practices and adherence to Medical Center policies, and should be addressed as such.

Other Conclusions:

- The Medical Center's first evaluation of (b) (6) for impairment did not comply with the procedures outlined in VA Handbook 5019, *Occupational Health Services*.
- (b) (6) was noncompliant with VHA Directive 2011-007, *Required Hand Hygiene Requirements*.
- Gloves were not readily available in the patient care area where Veteran 1 was being treated.
- It is not clear whether (b) (6)' treatment of the patient on January 7, 2014, negatively impacted the patient's condition.
- Veteran 3's death was not caused or hastened because he did not receive his mechanical lift.

The Medical Center has a peer review process in place to review cases involving PM&RS aspects of care.

Recommendations to the Medical Center:

1. Monitor (b) (6) compliance with documentation requirements, and address noncompliance with additional training and administrative and disciplinary action as indicated.
2. Monitor (b) (6) compliance with maintaining patient privacy. Address any noncompliance with the appropriate disciplinary and administrative action as indicated.
3. Provide training to appropriate staff about VA Handbook 5019 and the process for evaluating a Title 38 employee for impairment.
4. Review all remaining consultations performed by (b) (6) from October 1, 2013, to present. Evaluate whether (b) (6) findings address the concerns noted by the referring provider, and whether his proposed treatments are appropriate for the findings. If not, ensure patients receive an appropriate evaluation and treatment.
5. Provide additional training to (b) (6) about hand hygiene practices, as mandated in VHA Directive 2011-007; assess for compliance and address noncompliance with appropriate actions as indicated.
6. Ensure that gloves are readily available in all clinical areas within the PM&RS area.

7. Peer review the care provided to Veteran 2 by (b) (6).

Conclusions for Allegation 2

- VA **did not substantiate** that Medical Center officials have failed to respond to continuing concerns regarding (b) (6) impairment and incompetency.
- In accordance with the American College of Radiology (ACR) guideline for appropriateness, (b) (6) met the targeted performance goal of 90 percent for ordering MRIs. The Chief of Radiology's review of (b) (6) MRI orders determined that all orders met the guideline.
- Based on the information provided, (b) (6) reprivileging was appropriate.
- (b) (6) is compliant with copy and pasting requirements noted in the local and national VHA policies.
- When assigned as a co-signer, (b) (6) was compliant with the co-signature requirements.
- The Medical Center also completed other reviews of (b) (6) documentation as a result of the concerns voiced about his possible impairment
- Currently, a non-clinical staff member conducts medical record reviews to gather information for Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Performance Evaluation (FPPE) evaluations. OPPE and FPPE represent clinical reviews, and should therefore be completed by a clinician.
- No privacy violation occurred when the gerontologist accessed Mr. DeNofrio's medical record.

Recommendations to the Medical Center

8. Establish a process to ensure FPPEs are completed in a timely manner, once potential performance issues are identified and additional follow up is indicated.
9. Re-assign the task of medical record review for OPPE and FPPE evaluations to a clinical staff member.

Summary Statement

VA has developed this report in consultation with other Veterans Health Administration (VHA) and VA offices to address OSC's concerns that the Medical Center may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, or created a substantial and specific danger to public health and safety. In particular, the Office of General Counsel (OGC) has provided a legal review, and the Office of Accountability Review (OAR) has examined the issues from a Human Resources (HR) perspective to establish accountability, when appropriate, for improper personnel practices. VA found violations of VA and VHA policy.



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I. Introduction

The I/USH requested that OMI assemble and lead a VA team to investigate allegations lodged with OSC concerning the Medical Center's PM&RS. The whistleblowers, both of whom consented to the release of their names, alleged that employees are engaging in conduct that may constitute violations of laws, rules or regulations, and gross mismanagement, which may lead to a substantial and specific danger to public health. The VA team conducted a site visit to the Medical Center on February 9–11, 2015, and conducted additional interviews by telephone on February 17–18, 2015.

II. Facility Profile

The Medical Center, part of Veterans Integrated Service Network (VISN) 4, serves over 87,000 Veterans in central Pennsylvania with a comprehensive range of general medical, specialty clinics, and long-term health care services. Of its authorized 68 operating beds, 28 are assigned to acute care and 40 to long-term care. PM&RS, along with P&OT, provided 14,476 episodes of care during fiscal year (FY) 2013 and 13,746 during FY 2014 to inpatients and outpatients. The Medical Center has a medical resource-sharing agreement with the Department of Defense and graduate and undergraduate program affiliations with several universities and colleges.

III. Specific Allegations of the Whistleblowers

1. (b) (6), PM&RS chief, appears to be neurologically impaired and incompetent, yet continues to treat patients; and
2. Altoona VAMC officials have failed to respond to the continuing concerns regarding (b) (6) impairment and incompetency.

IV. Conduct of Investigation

The VA team conducting the investigation consisted of (b) (6), Interim Director, OMI; (b) (6), Medical Investigator; (b) (6) Clinical Program Manager; and (b) (6), HR Specialist, OAR. VA reviewed relevant policies, procedures, professional standards, reports, memorandums, and other documents listed in Attachment A. We toured the Medical Center's PM&RS area, and held entrance and exit briefings with VISN leadership.

VA interviewed both whistleblowers via teleconference on February 4, 2015, and in person on February 9, 2015. The team also interviewed the following Medical Center employees:

- (b) (6) Psychiatrist, Chief, PM&RS
- (b) (6), Chief, Geriatrics and Extended Care
- (b) (6), Patient Safety Manager

- (b) (6) ██████████, Quality Improvement Consultant/Accreditation
- (b) (6) ██████████, Occupation Therapist
- (b) (6) ██████████, Physical Therapist
- (b) (6) ██████████, Risk Manager
- (b) (6) ██████████, Social Worker
- (b) (6) ██████████, Physical Therapist
- (b) (6) ██████████, Prosthetics Supervisor
- (b) (6) ██████████, Credentialing Coordinator
- (b) (6) ██████████, Physical Therapy Assistant
- (b) (6) ██████████, Chief, Primary Care
- (b) (6) ██████████, Compliance Officer/ Executive Assistant for the Medical Center
- Director
- (b) (6) ██████████, PM&RS Secretary
- (b) (6) ██████████, Audiologist
- (b) (6) ██████████, Occupational Therapist
- (b) (6) ██████████, Medical Center Director
- (b) (6) ██████████, Physical Therapist
- (b) (6) ██████████, IT Specialist
- (b) (6) ██████████, MD, Chief of Staff
- (b) (6) ██████████, Primary Care
- (b) (6) ██████████, Chief, Quality Management Service
- (b) (6) ██████████, Certified Registered Nurse Practitioner
- (b) (6) ██████████, HR Labor Relations Specialist
- (b) (6) ██████████, Audiologist
- (b) (6) ██████████, Physician Assistant
- (b) (6) ██████████, Social Worker
- (b) (6) ██████████, Occupational Therapy
- (b) (6) ██████████, VISN 4 Prosthetic Manager
- (b) (6) ██████████, MD, Physiatrist
- (b) (6) ██████████, Physical Therapist
- (b) (6) ██████████, Medical Service Assistant (former secretary in PM&RS)
- (b) (6) ██████████, Acting VISN 4 Chief Medical Officer
- (b) (6) ██████████, HR Specialist
- (b) (6) ██████████, Physical Therapist Assistant
- (b) (6) ██████████, Speech Pathologist
- (b) (6) ██████████, Psychologist
- (b) (6) ██████████, Audiologist
- (b) (6) ██████████, Patient Advocate
- (b) (6) ██████████, Prosthetics
- (b) (6) ██████████, Occupational Health Physician
- (b) (6) ██████████, Chief, Acute and Long Term Care Service
- (b) (6) ██████████, Privacy Officer

VI. Findings, Conclusions, and Recommendations

PM&RS, also referred to as physiatry, is a medical specialty concerned with diagnosis, evaluation, and management of persons of all ages with painful or functionally limiting conditions that may produce temporary or permanent impairment.¹ The goal of physiatry is to decrease pain and enhance performance and quality of life.

Rehabilitation physicians, also known as physiatrists, are nerve, muscle, and bone experts who treat injuries or illnesses that affect movement.² These physicians complete training in the PM&R specialty and treat a wide range of problems from sore shoulders to spinal cord injuries. Physiatrists are trained in the diagnosis and management of impairments of the musculoskeletal system, rehabilitation of neurologic disorders, and the long-term management of patients with disabling conditions. A physiatrist can be a medical doctor (MD) or a doctor of osteopathic medicine (DO).

(b) (6) is the chief of the PM&RS at the Medical Center. There is one other physiatrist in the department.

Allegation 1: (b) (6), PM&RS Chief, appears to be neurologically impaired and incompetent, yet continues to treat patients.

A practitioner is considered impaired when a condition exists that interferes with their ability to engage safely in professional activities. Conditions are not limited to physical or neuropsychiatric ailments, disabilities, or chemical addiction.³ A practitioner may be unable to care for his or her patients with reasonable skill, attention, or safety if suffering from one of these impairing conditions.⁴

VA Handbook 5019, *Occupational Health Services*, Part III, describes the process for determining whether a Title 38 employee (including physicians) is suffering from a physical or mental impairment. The employee should have an initial general medical evaluation, and if indicated, be referred for additional specialized diagnostic studies. "A special examination may be required to solve questions of physical or mental ability to properly perform the duties of a position."⁵ The results of the diagnostic testing will be reviewed by the Occupational Healthcare Provider, and any abnormal results will be referred to a Physical Standards Board (PSB). The PSB is responsible for determining physical fitness and recommending actions based on examination findings. Consisting of a minimum of three physicians with a physician as the chairperson, the PSB submits its report to the appropriate officials, who in this case, would be the Medical Center Director and Chief of Staff for necessary action. If the Board determines a person to be physically and/or mentally incapable of performing his or her assigned duties, the Medical Center Director may grant leave or take action to transition the employee to disability or disability retirement status.

¹ American Academy of Physical Medicine and Rehabilitation (www.aapmr.org)

² Ibid.

³ American Medical Association, *Reporting Impaired, Incompetent, or Unethical Colleagues*, Opinion 9.031, www.ama-assn.org.

⁴ Medical Center Memorandum (MCM) 11-14, *Health Status and Impaired Practitioner Program*. October, 2013.

⁵ VA Handbook 5019, *Occupational Health Services*. April 15, 2002

In April 2013, both whistleblowers began reporting their allegations of (b) (6) impairment to the Medical Center Director, who shared this information with the Chief of Staff. On (b) (6) 2013, Medical Center leadership sent (b) (6) for evaluation by a neurologist who is not associated with the VA. The neurological evaluation revealed mild difficulty with memory but excellent judgment and insight, excellent grasp of clinical medicine with attention to detail, and normal diagnostic testing results. On (b) (6) 2013, he underwent further neuropsychological testing which concluded that, (b) (6) was not found to have dementia or significant intellectual compromise, and is currently capable of performing his assigned duties as a licensed physician.” After obtaining permission from (b) (6), the test results were shared with the whistleblowers. The whistleblowers allege that (b) (6) has continued to decline since that time.

Because the Chief of Staff judged that the whistleblowers’ allegations about (b) (6) could be related to a possible neurological condition, she referred (b) (6) for neurological and neuropsychological evaluations rather than for an initial general medical evaluation, as required in VA Handbook 5019. After reviewing the results of these evaluations, Medical Center leadership requested guidance from a variety of sources, including the local HR department, the VISN 4 Chief Medical Officer, and Regional Counsel. These consultants advised the Medical Center that no additional actions were indicated since the results did not indicate the presence of impairment.

Specific Allegations Related to Allegation 1:

- I. **During the spring of 2013, (b) (6) began forgetting significant information like names of employees with whom he had worked for years.**

Other than the whistleblowers, no staff members interviewed recalled any instances when (b) (6) forgot the names of employees with whom he worked with for years. One staff member described an incident during which (b) (6) did not remember that an employee had retired the day before, but no one else had knowledge of this incident. No other witnesses recalled instances when (b) (6) was unable to remember a staff member’s name.

During the VA site visit, (b) (6) conducted the tour of the PM&RS department spaces, and was readily able to describe each area and its designated purpose as well as each piece of equipment and its indication for use. He identified several staff members by name and explained his or her position to investigators, and provided rational answers to all questions posed to him. During his subsequent formal interview, (b) (6) was tangential at times, providing information unrelated to questions posed by the team, but was easily redirected to answer questions with the appropriate information. Three of the PM&RS professional staff members indicated that they thought (b) (6) was more forgetful than in the past. All other staff members, including providers in other departments who refer patients to (b) (6) for

consultation, stated that he does not seem more forgetful than before and could cite no evidence that his ability to perform his job has been negatively impacted.

- II. He also began forgetting administrative tasks such as how to use email. Several staff members also expressed concerns about his (b) (6) ability to perform his duties and treat patients and have reported to Mr. DeNofrio and Mr. Skarada that (b) (6) is forgetful, cannot perform administrative duties, and frequently requests assistance for tasks he was able to perform in the past. He becomes confused when faced with administrative changes or instructions, and appears to be uncertain about which employees he supervises.**

Two staff members indicated that (b) (6) had sought their assistance with accessing a computerized training module. Both staff members stated that accessing and navigating the module was more difficult than usual, and once they had helped him access the training, he was able to complete it without further assistance. The computer specialist provided (b) (6) additional training and assistance with navigating the computer system, but noted that he needed no more assistance than many others, and she did not consider the amount of assistance he needed to be either excessive or concerning. (b) (6)' current and previous secretaries stated they have never been asked to provide him assistance with email. Some witnesses stated that (b) (6) had asked for help accessing radiographic images; their impression was that he was not asking for their interpretation of the radiograph, but assistance with accessing the electronic image from the patient's medical record. Two therapists assisted him with retrieving radiographic studies; one stated (b) (6) asked him his interpretation of the study and one stated (b) (6) had only asked her to bring the study up on the screen. All providers and administrative staff members indicated that they have never been asked to assist (b) (6) in the performance of his duties, nor had they observed other staff members assisting him with the treatment of his patients.

- III. (b) (6) is increasingly confused and agitated and is prone to angry outbursts and erratic behavior.**

Other than the whistleblowers, no staff members reported witnessing any angry outbursts or erratic behavior displayed by (b) (6)

- IV. Mr. DeNofrio and Mr. Skarada also report that (b) (6) is frequently absent from their department during the day without explanation.**

According to staff members, (b) (6) is usually present in the department, or easy to locate if not present. (b) (6) secretary stated that if he is not present in the department, she is able to reach him by phone and he responds quickly to her calls and follows up on any messages she leaves for him. Currently, (b) (6) is assigned to 16 different committees and regularly attends meetings throughout the hospital. He is also actively involved with many of the Medical Center's public affairs activities and events. No witnesses reported instances when (b) (6) was on duty and not

available within a short period of time. Other than the whistleblowers, no staff members recalled any instance when they witnessed (b) (6) leaving the Medical Center prior to the end of his shift.

Some staff members noted that (b) (6) is frequently late for meetings and at times appears unclear about the purpose of the meeting. However, they stated he participates appropriately, and while at times his verbal input is tangential, he is easily redirected to the topic(s) at hand.

- V. When (b) (6) is present, he has been observed treating patients he meets in the waiting room or hallway without a consult referral or scheduled appointment. (b) (6) makes clinical recommendations to patients in the physical and occupational therapy gym even though the patients were not referred to him nor was he previously involved in their treatment.**

Some physical and occupational therapists stated that (b) (6) makes recommendations to patients he observes while passing through the gym or the P&OT hallway. Based on his brief observation, he may recommend using an assistive device (e.g., walker, cane, wheelchair, etc.) that he believes would improve the patient's mobility. Some staff members expressed concern that (b) (6) is recommending these treatment modalities without formally assessing the patient. The patients in question were not referred to (b) (6) for consultation, and are not patients he was currently treating. Other physical and occupational therapy staff stated that they did not believe (b) (6) was attempting to treat these patients himself, but rather encouraging PM&RS staff to arrange follow up with the patient's appropriate provider to obtain assistive devices needed to improve mobility. Witnesses noted this has always been (b) (6) practice and is not a change in his approach.

The whistleblowers alleged that (b) (6) discusses confidential information, such as the reason for the patient's appointment, with patients in the hallways of the PM&RS area. No other staff members recalled witnessing such occurrences. (b) (6) told VA that these discussions occurred in nonprivate areas because the patients are anxious to discuss their concerns with him and frequently begin the conversation before they reached a private area where confidentiality can be maintained. On (b) (6) 2015, the Chief of Staff counseled (b) (6) about this violation of patient privacy.

- VI. (b) (6) repeatedly failed to communicate with primary care providers and treating therapists regarding his clinical treatment and recommendations, or changes he made to treatment plans.**

All health care providers that we interviewed stated that (b) (6) responds to consults in a timely manner, and communicates his findings and recommendations to them electronically or in a face-to-face conversation. The Chief of Staff noted one instance in which (b) (6) failed to complete documentation for a Community

Living Center (CLC) patient who had been referred to him. In this instance (b) (6) failed to document his findings after evaluating the patient and before departing for 11 days of scheduled leave. During this period, no one was able to determine what (b) (6) findings and recommendations were. He was verbally counseled about this documentation lapse. No other providers could recall any other occasions when (b) (6) failed to communicate with primary care or referring providers regarding his clinical treatment and recommendations.

Mr. DeNofrio identified eight cases in April 2014 as evidence that (b) (6) did not consistently communicate his findings and recommendations with the appropriate provider. In May 2014, the Chief of Quality Management reviewed the eight cases and identified two in which there was no documentation that (b) (6) had notified patients of their MRI results. The review did not find evidence that (b) (6) consistently failed to communicate results with other providers involved in the patients' care.

VII. (b) (6) documentation of patient encounters is consistently poor and frequently assesses the wrong diagnosis or does not address the condition for which the patient was referred to him.

PM&RS staff members said that (b) (6) documentation had become more difficult to read because of numerous spelling and grammatical errors. At that time, (b) (6) had started using a speech recognition program for documentation of his notes. Because the speech recognition software was not familiar with some of the medical terminology he included in his dictations, it changed or misspelled many of the words in his notes. With continued use, the software correctly recorded the terminology used by (b) (6), and the quality of his notes returned to the previously acceptable standard. VA was unable to review evidence of (b) (6) spelling and grammatical errors in health records because staff members were unable to provide the names of the patients in whose medical records these errors had occurred.

VA reviewed 50 consultation notes completed by (b) (6). Of the 50, 46 appropriately addressed the concern for which the patient was referred. However, four did not address the concern, and in some instances there is no evidence that (b) (6) examined the body part or region identified as the area of concern by the referring provider.

VIII. (b) (6) has engaged in questionable and inappropriate treatment of patients at the VA. For example, in (b) (6) 2014, (b) (6) conducted a hernia examination on an individual who was not his patient, did not follow proper hygiene protocol, did not document the examination in the patient's records, and later that day did not recall examining the patient.

The whistleblowers identified three patients whom they alleged received questionable and inappropriate treatment from (b) (6). Review of their care revealed:

Veteran 1 is an 84-year-old male hospitalized for an acute change in his mental status, who was admitted to the Medical Center's CLC for reconditioning in preparation for discharge home. The patient was receiving P&OT while residing in the CLC. According to both staff members present at the time of the incident, the Veteran was in PM&R for treatment and was very unsteady on his feet. Both therapists were supporting him in order to keep him in a standing position and prevent him from falling. One of the therapists suspected that the patient might have had a hernia, and summoned (b) (6) to examine him. When (b) (6) arrived, he checked his pockets and discovered he did not have any examination gloves. According to both staff members, there were no exam gloves in the area, and (b) (6) proceeded to conduct the examination without gloves. (b) (6) stated he conducted the examination without gloves because he was concerned the therapists would not be able to keep the patient upright much longer. According to one of the therapists, (b) (6) did not wash his hands before or after examining the patient. By not doing so, (b) (6) failed to comply with standard precautions, as directed in VHA Directive 2011-007, *Required Hand Hygiene Practices*, which states, "All health care workers in direct patient contact areas, i.e., inpatient rooms, outpatient clinics, etc., as well as those who may have direct patient contact in other settings, such as radiology technicians, phlebotomists, etc., are required to use an alcohol-based hand rub or antimicrobial soap and water to routinely decontaminate their hands before and after having direct contact with a patient."

Veteran 2 is a 38-year-old male with a history of mid- and low back pain and PTSD. On (b) (6) 2014, he presented to the Emergency Department (ED) for evaluation and treatment of shortness of breath. A diagnosis of right-sided pneumonia was made and the Veteran was given medication and discharged. After discharge from the ED he went to PM&RS, asking for treatment of his rib pain. The PM&RS staff was unable to provide any treatment at that time because of the patient's continued discomfort and difficulty breathing. On (b) (6) the patient was seen for follow up by his primary care provider (PCP), who referred him to PM&RS for therapy. After being evaluated and treated by (b) (6), the patient stated his rib pain was greatly improved. According to a fact finding inquiry conducted by the Medical Center (b) (6) contacted the patient's wife later that day to inquire about how the patient was feeling. The wife informed (b) (6) that the patient was in pain again, and (b) (6) offered to give her instructions for performing an arm manipulation to relieve his pain. The wife stated she was not comfortable performing the maneuver, and declined. On (b) (6) the patient began complaining of chest pain with a cough. He was re-evaluated in the ED and treated with medication, and discharged home. On (b) (6) he was re-evaluated in the ED for worsening pneumonia. He was admitted for inpatient care and transferred to the Pittsburgh VA Health Care System (VAHCS) for thoracentesis and additional treatment. It is unclear whether (b) (6) treatment on (b) (6) negatively impacted the patient's condition and led to a worsening of his condition.

The whistleblowers voiced a concern about the care provided by (b) (6) to Veteran 2. Peer review is defined as "an organized process carried out by an individual

health care professional or select committee of professionals, to evaluate the performance of other professionals in the health care setting." A peer review of a patient's care is indicated when unexpected or negative occurrences take place and may be related to the care provided. Per VHA Directive 2010-025, *Peer Review for Quality Management*, "It is VHA policy that each VISN and health care facility must establish and maintain a program of peer review for quality management purposes relevant to the care provided by the individual health care provider." Currently, only two psychiatrists are on staff at the Medical Center. At the time of the site visit, the Chief of Staff described the peer review process in PM&RS as collaboration with the Pittsburgh VAHCS where a mutual exchange of psychiatrist peer reviews takes place between the two facilities to evaluate cases involving PM&RS aspects of care.

Veteran 3 was a 64-year-old male diagnosed with lung cancer with brain metastasis in (b) (6) 2013. The Veteran's condition continued to decline and his caregiver requested a mechanical lift to assist with caring for the Veteran at home. On (b) (6) 2014, his PCP ordered a mechanical lift for the Veteran. Prior to delivery of the lift, the Veteran's living quarters needed to be evaluated and the caregiver trained how to use the lift safely. Because the Veteran was not enrolled in the Home Based Primary Care (HBPC) program, the HBPC Occupational Therapist was not authorized to perform the evaluation. On (b) (6) (b) (6) was instructed by the Chief of Staff to address this consult for the lift; however, the Veteran died the same day. Since this time, the Medical Center has developed a process for addressing similar issues for non-HBPC patients who need a service usually provided by the HBPC team. There is no evidence that the patient's death was caused by or hastened by his not having the mechanical lift.

(b) (6) underwent thorough, independent neurological and neuropsychological evaluations in (b) (6) 2013, the results of which indicated no impairment at that time. However, some (but not all) witnesses described occasional incidents of forgetfulness, slight confusion, or questionable judgment since then. (b) (6) failed to communicate his findings and recommendations for treatment to the referring provider in at least three instances, while in other cases his documentation of consultation findings did not address the main reason for the consultation. The signs of early cognitive impairment in aging physicians can be subtle, and the evidence represented by these witness statements and medical record entries is inconclusive. For these reasons VA believed that a general medical and repeat cognitive evaluation was warranted. During our site visit, VA investigators discussed the proper procedures with the Medical Center Director and Chief of Staff, who subsequently initiated the process to have (b) (6) re-evaluated.

On March 2, 2015, the Medical Center leadership removed (b) (6) from direct patient care activities pending the results of the re-evaluation. On (b) (6) 2015, (b) (6) underwent a fitness for duty evaluation to determine if he was neurologically and cognitively impaired. He was evaluated by a general medicine physician and a neurologist. The neurologist concluded there was "no evidence of neurological disease that would compromise his physician-physiatrist duties." The

general medicine physician concluded that (b) (6) "did not appear to have any significant cognitive deficits during the examination." Both evaluators concluded that (b) (6) did not have any significant cognitive deficits or neurological disease based on their examinations. Since his evaluations revealed no evidence of impairment, some of the issues identified would be considered noncompliance with accepted physician practices and adherence to Medical Center policies, and should be addressed as such.

Conclusions:

VA did not substantiate that (b) (6) is neurologically impaired and incompetent. He underwent thorough, independent neurological and neuropsychological evaluations in (b) (6) 2013, the results of which indicated no evidence of impairment at that time. Some (but not all) witnesses described occasional incidents of forgetfulness, slight confusion, or questionable judgment since then. (b) (6) failed to communicate his findings and recommendations for treatment to the referring provider in at least three instances, while in other cases his documentation of consultation findings did not address the main reason for the consultation. He underwent a general medicine and neurological evaluation in (b) (6) 2015, the results of which also indicated no evidence of impairment. Since his evaluations revealed no evidence of impairment, some of the issues identified would be considered noncompliance and should be addressed as such.

Other Conclusions:

- The Medical Center's first evaluation of (b) (6) for impairment did not comply with the procedures outlined in VA Handbook 5019, *Occupational Health Services*.
- (b) (6) was noncompliant with VHA Directive 2011-007, *Required Hand Hygiene Requirements*.
- Gloves were not readily available in the patient care area where Veteran 1 was being treated.
- It is not clear whether (b) (6) treatment of the patient on (b) (6) 2014, negatively impacted the patient's condition.
- Veteran 3's death was not caused or hastened because he did not receive his mechanical lift.

Recommendations to the Medical Center:

1. Monitor (b) (6) compliance with for documentation requirements, and address noncompliance with additional training and administrative and disciplinary action as indicated.
2. Monitor (b) (6) compliance with maintaining patient privacy. Address any noncompliance with the appropriate disciplinary and administrative action as indicated.
3. Provide training to appropriate staff about VA Handbook 5019 and the process for evaluating a Title 38 employee for impairment.
4. Review all remaining consultations performed by (b) (6) from October 1, 2013, to present. Evaluate whether (b) (6) findings address the concerns noted by the referring provider, and whether his proposed treatments are appropriate for the findings. If not, ensure patients receive an appropriate evaluation and treatment.
5. Provide additional training to (b) (6) about hand hygiene practices, as mandated in VHA Directive 2011-007; assess for compliance and address noncompliance with appropriate actions as indicated.
6. Ensure that gloves are readily available in all clinical areas within the PM&RS area.
7. Peer review the care provided to Veteran 2 by (b) (6).

Allegation 2: Altoona VAMC officials have failed to respond to the continuing concerns regarding (b) (6) impairment and competency. Specifically:

- I. (b) (6) did not meet the target performance goals of 90 percent for ordering MRIs according to the appropriate standard. (b) (6) performance was measured at 73 percent, and (b) (6) changed the standard used to evaluate (b) (6) use of MRIs in order to avoid triggering a review of his performance. Even under the altered standard, (b) (6) continued to fail this performance measure in FY 2014.

One of the criteria the Medical Center assessed for OPPE in FYs 2013 and 2014 was appropriateness of ordering of MRIs. Evaluation of providers' performance was based on the McKesson InterQual® criteria, which are used to determine whether a service is clinically indicated and provided at the appropriate level of care. When evaluated under the InterQual criteria, (b) (6) performance rate was 73 percent, less than the targeted performance goal of 90 percent.

To more clearly evaluate the appropriateness of MRI orders, the Chief of Staff instructed the Chief of Radiology to conduct a second level review of (b) (6) orders for MRIs to determine appropriateness according to the patient's condition. The

Chief of Radiology reviewed 599 orders from October 2013 through June 2014. He applied specialty-specific criteria determined by the American College of Radiology, a professional organization for radiologists that identifies best practices based on evidence-based information and develops guidelines for appropriate use of radiology studies to maintain the ACR Appropriateness Criteria® (AC). These criteria assist referring physicians and other providers in making the most appropriate imaging or treatment decision for specific clinical conditions.⁶ The Chief of Radiology determined that all 599 orders met the ACR guidelines for appropriateness. He also reviewed all 13 MRI orders submitted by (b) (6) from July 1, through December 31, 2014, and concluded that all of these met the ACR criteria for appropriateness as well.

- II. **Additionally, in the last quarter of 2014, (b) (6) achieved an 87 percent success rate on the measure for inappropriate copying and pasting in patient records, where the target rate is 95 percent. In October 2014, (b) (6) achieved only 40 percent in the area of inappropriate copying and pasting. (b) (6) performance should have initiated a Focused Professional Performance Evaluation (FPPE), but no FPPE was initiated. He also had a success rate of 73 percent for the measure of unsigned co-signatures greater than 72 hours, where the target rate is 95 percent.**

According to VHA Handbook 1907.01, *Health Information Management and Health Records*, and Medical Center Memorandum 10M-04, *Computerized Patient/Resident Record System (CPRS)*, the copy-and-paste function and object importing is allowed but must be used with caution.⁷ Diagnostic findings can be copied into the record when it is pertinent to the assessment of a specific patient problem or care provided.⁸ During the third quarter of 2014, (b) (6) compliance was assessed at 87 percent due to copying and pasting of diagnostic results. The targeted measure assessed the percentage of copying and pasting that was appropriate versus that which is not inappropriate. Mr. DeNofrio reported this information to Medical Center leadership, who then requested an FPPE be conducted for a 3-month period (August, September, and October 2014) to assess compliance. There is no evidence that the FPPE was completed. During October 2014, (b) (6) compliance was assessed at 40 percent. The Medical Center leadership again requested an FPPE for a 3-month period. This evaluation was completed and the Medical Center determined that (b) (6) copied and pasted the results of diagnostic findings, but did not copy and paste other clinicians' assessments into his note without indicating the source. This review also determined that (b) (6) documented assessments were not copied and pasted from another providers' notes. Based on these findings, the Medical Center determined that (b) (6) was compliant with copy-and-paste requirements. The VA team also reviewed the notes in question and found no evidence of inappropriate copying and pasting. Mr. DeNofrio provided the names of six patients whose charts reflected inappropriate copying and pasting by (b) (6) in January 2015. The VA team reviewed these and found no instances of inappropriate copying and pasting.

⁶ The American College of Radiology. (<http://www.acr.org/Quality-Safety/Appropriateness-Criteria>)

⁷ VHA Handbook 1907.01, *Health Information Management and Health Records*. July 22, 2014.

⁸ Medical Center Memorandum (MCM) 10M-04, *Computerized Patient/Resident Record System*. October 2013.

Each note entered in the electronic medical record requires the signature of the individual entering the note, known as the "signer." Notes completed by trainees and other non-independent practitioners require signature by a co-signer, known as a cosignature. A co-signer is a supervising practitioner who has the overall responsibility for the care of the patient. A co-signature indicates responsibility for the contents of the note and concurrence with the note. If assigned a cosigner, the note requires signature by the co-signer. In contrast, an additional signer designation is a communication tool used to alert a clinician about information pertaining to the patient, and allows the recipient to acknowledge receipt of that information. Being an additional signer does not imply responsibility for the content of, or concurrence with, the note, as co-signature does.⁹

During FY 2014 the Medical Center tracked the percentage of notes assigned for co-signature that were completed within 72 hours. The target rate was 95 percent and (b) (6) rate was 73 percent. An FPPE was not initiated, because the Quality Manager reviewed notes identified as lacking a co-signature within 72 hours, and found that (b) (6) was assigned as an additional signer, not as a co-signer, and therefore was not required to co-sign the note or acknowledge receipt of the note. The VA team also reviewed the notes identified as lacking co-signature within 72 hours, and found no evidence that (b) (6) was non-compliant with co-signature requirements. Mr. DeNofrio provided the names of eight patients whose charts he alleged showed evidence of (b) (6) failure to cosign notes within 72 hours after being written by the primary author. The notes identified by the Mr. DeNofrio were written in December 2014 and January 2015. The VA team reviewed the notes and found that two of the eight notes were assigned to (b) (6) for co-signature, and were signed within 72 hours; Mr. DeNofrio identified one that was a consultation note written by (b) (6) and would not require co-signature by the primary author, and the remaining five were assigned to other clinicians for co-signature.

- III. (b) (6) (Medical Center Director) approved (b) (6) re-credentialing for clinical privileges in July 2014, even though (b) (6) failed to meet numerous goals established in the Ongoing Professional Practice Evaluation (OPPE) criteria during FY 2013 and 2014.

In order to ensure providers are qualified to provide care, the facility conducts periodic reviews of each provider's credentials and privileges. According to VHA Handbook 1100.19, *Credentialing and Privileging*, "all VHA health care professionals who are permitted by law and the facility to provide patient care services independently, must be credentialed and privileged as defined in this Handbook." The term "credentialing" refers to the systematic process of verifying professional qualifications: such as current state licensure, satisfactory completion of medical school and postgraduate residency education, required continuing education, and health status. Providers are assessed by recredentialing every 2 years.

⁹ VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014

Per that Handbook, clinical privileging is defined as “the process by which a practitioner, licensed for independent practice (i.e., without supervision, direction required sponsor, preceptor, mandatory collaboration, etc.), is permitted by law and the facility to practice independently, to provide specified medical or other patient care services within the scope of the individual’s license, based on the individual’s clinical competence as determined by peer references, professional experience, health status, education, training and licensure.”¹⁰ Clinical privileges must be facility-specific, practitioner-specific, and within available resources. Clinical privileges are initially granted at the time of initial appointment to the medical staff, and are granted for a period not to exceed 2 years. The reprivileging process must be conducted at least every 2 years, but prior to the expiration of current privileges.¹¹

In order to ensure a provider is competent and remains competent to provide high quality care, ongoing and focused monitoring of privileged practitioners is conducted. OPPE is used to confirm the quality of care delivered and helps the facility identify professional practice trends that impact the quality of care and patient safety.¹² An FPPE is a time-limited evaluation period during which the medical staff leadership evaluates the practitioner’s performance. An FPPE may be used within the first few months after a new provider has joined the medical staff or when a question arises regarding a currently privileged practitioner’s ability to provide safe, high-quality care.¹³ These evaluations should be conducted by peers or supervisors of the provider being assessed. Currently, Mr. DeNofrio, a non-clinician and therefore not a peer of (b) (6), conducts the medical record reviews to gather information for FPPE and OPPE evaluations.

On July 23, 2014, (b) (6) was due for reappraisal for the biannual renewal of clinical privileges. His compliance with MRI ordering appropriateness was 100 percent, his copy-and-paste compliance was below the targeted range, and an FPPE was requested. No documented issues with patient care were found, and there were no incidents of adverse licensure, hospital privilege or professional society actions or malpractice payments reported about (b) (6) to the national database that collects this information. His evaluation revealed no indication of impairment.

Additional reviews done by the Medical Center:

Mr. DeNofrio identified eight cases in April 2014 in which (b) (6) did not consistently communicate his findings and recommendations with the appropriate provider. In May 2014, Quality Management reviewed the cases and identified two in which there is no documentation that the patient had been notified of MRI results by (b) (6); they did not find evidence that (b) (6) consistently failed to communicate results with other providers involved in the patients’ care.

¹⁰ VHA Handbook 1100.19, *Credentialing and Privileging*. October 15, 2012.

¹¹ Ibid.

¹² Ibid.

¹³ Ibid.

In June 2014, Mr. Skarada alleged that (b) (6) notes failed to adequately document assessments, address appropriate diagnostic studies, appropriate recommendations or follow up information. In July 2014, the Medical Center conducted a review of (b) (6) notes and found that each note contained a detailed assessment, impression, recommendations and indications that the recommendations had been acted upon in a timely manner.

At the request of the Chief of Staff in July 2014, the Chief, Acute Medicine and Procedure Clinic Service, conducted a review of several of (b) (6) notes. He found one instance in which (b) (6) had not documented MRI results or notified the patient's PCP about the results. At that time, the reviewer recommended that the PCP, instead of PM&R providers, order MRI studies as a part of the consult; his rationale was that the PCP should be more involved in the patient's care and follow up. He also found that (b) (6) documentation did not negatively impact patient care or safety.

Although not included in the list of concerns provided by the OSC, Mr. DeNofrio voiced a concern that a staff member inappropriately accessed his medical record. He alleged a gerontologist was instructed by the Chief of Staff to review his medical record without a clinical indication since he does not receive geriatric care. Mr. DeNofrio is a Veteran and receives his care at the Medical Center as well as at another VA medical center.

Investigation of this concern revealed that the Chief of Staff assigned the gerontologist the additional duty of reviewing non-VA care consultations. As such, it was the gerontologist's responsibility to review Mr. DeNofrio's medical record to determine whether Mr. DeNofrio should be scheduled sooner and locally for a non-VA care appointment; he was scheduled to be seen at another VA medical center approximately 97 miles away, where he was also receiving care. The gerontologist reviewed the record and determined that local, non-VA care was indicated. Mr. DeNofrio reported his concern to the VA Central Office (VACO) Privacy Office. The VACO Privacy Office determined no privacy violation had occurred, since the gerontologist's review of the record was within the scope of his clinical duties.

Conclusions:

- VA did not substantiate that Medical Center officials have failed to respond to continuing concerns regarding (b) (6) impairment and incompetency.
- In accordance with the ACR guideline for appropriateness, (b) (6) met the targeted performance goal of 90 percent for ordering MRIs. The Chief of Radiology's review of (b) (6) MRI orders determined that all orders met the guideline.
- Based on the information provided, (b) (6) reprivileging was appropriate.

- (b) (6) is compliant with copy and pasting requirements noted in the local and national VHA policies
- When assigned as a co-signer (b) (6) was compliant with the co-signature requirements.
- The Medical Center also completed other reviews of (b) (6) documentation as a result of the concerns voiced about his possible impairment
- Currently, a non-clinical staff member conducts medical record reviews to gather information for OPPE and FPPE evaluations. OPPE and FPPE represent clinical reviews, and should therefore be completed by a clinician.
- No privacy violation occurred when the gerontologist accessed Mr. DeNofrio's medical record.

Recommendations to the Medical Center

8. Establish a process to ensure FPPEs are completed in a timely manner, once potential performance issues are identified and additional follow up is indicated.
9. Re-assign the task of medical record review for OPPE and FPPE evaluations to a clinical staff member.

Summary Statement

VA has developed this report in consultation with other VHA and VA offices to address OSC's concerns that the Medical Center may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, or created a substantial and specific danger to public health and safety. In particular, the OGC has provided a legal review, and OAR has examined the issues from an HR perspective to establish accountability, when appropriate, for improper personnel practices. VA found violations of VA and VHA policy.

Attachment A

Documents Reviewed in Addition to the Electronic Medical Record:

American College of Radiology Order Appropriateness Criteria

Credentialing and Privileging folder for (b) (5)

Findings of VACO Privacy Office

McKesson InterQual Criteria for MRI Order Appropriateness

Medical Center Memorandum (MCM) 10M-04, *Computerized Patient/Resident Record System (CPRS)*. October 2013

MCM 11-01, *Medical Staff Executive Committee*. October 2013

MCM 11-09, *Peer Review Processes*. October 2013

MCM 11-14, *Health Status and Impaired Practitioner Program*. October 2013

Medical Center's Medical Staff Bylaws, Rules and Regulations and Policies. 2013

Medical Staff Executive Committee Meetings Minutes

Neurological and Neuropsychological testing results

Occupational Health Record for (b) (6)

Performance Appraisals for (b) (6)

Reports of Contacting involving PM&RS

Results of OPPE and FPPE reviews

VA Handbook 5019, *Occupational Health Services*. October 15, 2002

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

VHA Directive 2012.030, *Credentialing of Health Care Professionals*. October 11, 2012

VHA Handbook 1100.19, *Credentialing and Privileging*. October 15, 2012

VHA Handbook 1907.01, *Health Information Management and Health Records*. July 22, 2014