



DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

January 6, 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-14-3495 and DI-14-3503

Dear Ms. Lerner:

I am responding to your July 29, 2014, letter regarding allegations made by two whistleblowers at the Fort Detrick Community Based Outpatient Clinic (CBOC) of Martinsburg Department of Veterans Affairs (VA) Medical Center (hereafter, the Medical Center), Martinsburg, West Virginia. (b)(6) and (b)(6) alleged that the Medical Center and the CBOC engaged in conduct that may constitute a violation of law, rule or regulation, gross mismanagement, and a substantial and specific danger to public health. 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).

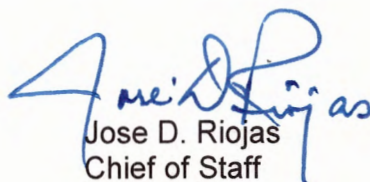
The Secretary asked that the Under Secretary for Health refer the whistleblower's allegations to the Office of the Medical Inspector, who coordinated a VA team that conducted a site visit to the Medical Center on September 30 – October 2, 2014.

VA substantiated the first allegation regarding staffing shortages and ongoing deficiencies due to the lack of appropriate staffing, and partially substantiated the second allegation regarding copying medical records and falsifying information in records. VA made 10 recommendations for the Medical Center, 1 recommendation for Veterans Integrated Service Network 5, and 2 recommendations for the Veterans Health Administration. I have instructed VA's Office of Accountability Review to assess senior leader accountability for the substantiated deficiencies and to coordinate accountability actions, as appropriate.

Findings from the current investigation are contained in the enclosed report, which I am submitting for your review.

Thank you for the opportunity to respond.

Sincerely,



Jose D. Riojas
Chief of Staff

Enclosure

**DEPARTMENT OF VETERANS AFFAIRS
Washington, DC**

**Report to the
Office of Special Counsel
OSC File Numbers DI-14-3495 and DI-14-3503**

**Department of Veterans Affairs
Martinsburg Veterans Affairs Medical Center
Martinsburg, West Virginia
and
Fort Detrick Community Based Outpatient Clinic
Frederick, Maryland**



Report Date: November 10, 2014

TRIM 2014-D-1253

Executive Summary

At the direction of the Secretary, the Under Secretary for Health (USH) asked the Office of the Medical Inspector (OMI) to assemble and lead a team to investigate complaints lodged with the Office of Special Counsel (OSC) by (b)(6) (hereafter, whistleblower 1), and (b)(6) (hereafter, whistleblower 2), at the Fort Detrick Community Based Outpatient Clinic (CBOC), Frederick, Maryland, whose parent facility is the Martinsburg Department of Veterans Affairs (VA) Medical Center (hereafter, the Medical Center), Martinsburg, West Virginia. The whistleblowers alleged that the Medical Center and the CBOC engaged in conduct that may constitute a violation of law, rule or regulation, gross mismanagement, and a substantial and specific danger to public health. The VA team conducted a site visit to the Medical Center and CBOC on September 30 – October 2, 2014.

Specific Allegations of the Whistleblowers

1. Martinsburg VAMC and Fort Detrick CBOC leadership failed to address chronic staffing deficiencies at Fort Detrick CBOC, which has adversely affected patients' access to care and resulted in serious risk to patients; and
2. In an effort to achieve performance measures, primary providers use templates to generate patient chart notes that include false and misleading information regarding the care and services provided during patient visits.

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 about whether the alleged event or action took place with reasonable certainty.

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

Conclusions for Allegation #1

- VA substantiated that Martinsburg VAMC and Fort Detrick CBOC leadership failed to address chronic staffing deficiencies in Fort Detrick CBOC's Patient Aligned Care Team (PACT), laboratory, and specialty care clinics, which has adversely affected patients' access to care and resulted in risk to patients.
- VA substantiated that current staffing levels at the CBOC are not in compliance with the PACT model per Veterans Health Administration (VHA) Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook*, and are inadequate to support the PACT model. Staff is supporting specialty clinics and the laboratory in addition to their assigned PACT.

- VA substantiated that current documented staffing levels in the Primary Care Management Module (PCMM) do not accurately reflect actual staffing, giving the appearance that all PACT teams are fully staffed.
- VA substantiated that coverage for staff absences is not appropriately provided for.
- VA substantiated that CBOC administrative staff did not carry out some orders for laboratory tests and requests for future appointments. Whistleblower 1 submitted six incident reports on six orders that were not carried out.
- VA substantiated that although none of the incidents reported by whistleblower 1 or the pharmacist warranted a root cause analysis (RCA), the Medical Center neither investigated the multiple incidents occurring in the CBOC over a 6-month period nor informed the CBOC Nurse Manager of the reports.
- VA substantiated that the CBOC does not have adequate administrative staff to consistently answer the phone and its telephone system is not user friendly.
- VA substantiated that a Veteran's caretaker was not able to speak with a staff member when she telephoned the CBOC on three separate occasions.
- VA did not substantiate that the Veteran experienced a preventable stroke and further decline as a result of not being able to reach any clinicians via telephone at the CBOC for medical advice.

Recommendations to the Medical Center

1. Develop a contingency plan to ensure adequate coverage during staff absences at the CBOC.
2. Document PACT staffing correctly in the PCMM. Take corrective action addressing the deficiencies identified in the PCMM audit conducted in June 2014.
3. Make sure specialty clinics have adequate administrative and clinical support that is not provided by PACT staff. Evaluate staffing needs and continue to fill vacancies as indicated.
4. Provide retraining about order verification to PACT clerical staff. Monitor for compliance and address noncompliance as indicated.
5. Conduct an audit of unverified orders for the CBOC for the previous 3 months, and determine if any patient harm occurred as a result of unverified orders. If patient harm occurred, make sure the Veteran is receiving care, and is informed of any adverse event if required by VHA Handbook 1004.8, *Disclosure of Adverse Events to Patients*.

6. Develop and implement a process for following up on incident reports that do not warrant an RCA. As the CBOC person charged with reviewing and addressing each incident as indicated, the Nurse Manager must have access to these reports.
7. Rectify the problems with the telephone system to make it more user friendly.

Recommendation to the Veterans Integrated Service Network (VISN) 5

8. VISN 5 should conduct an organizational assessment to identify the basis for communication breakdowns between the Medical Center, the CBOC and Human Resources (HR) around staffing issues impacting the CBOC's PACTs, laboratory, primary care, and specialty care clinics. This assessment should determine the root cause of the breakdowns and to establish a communication improvement plan to address the following: coverage for military leave, vacancies, and staffing needs to meet the demand for increased services.

Recommendation to VHA

9. Assess the need for tracking of Safety Assessment Code (1) incidents. If a need exists to track these, ensure they are tracked in a uniform manner across the system.

Conclusions for Allegation #2

- VA did not substantiate record copying in the electronic health records (EHR) of the six Veterans named by whistleblower 2.
- VA substantiated that a PACT provider had documented examinations not performed.

Recommendations to the Medical Center

10. Review 3 months of EHRs entered by the PACT provider named by the Veteran interviewed for any evidence of false data. If false data are found, take the appropriate disciplinary and oversight actions.
11. Review 3 months of EHRs entered by the other CBOC PACT providers for evidence of false data. If false data are found, take the appropriate disciplinary and oversight actions.
12. Provide additional training to providers on VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014, regarding the requirement for accurate documentation.

Recommendation to VHA

13. Consider exploring if copy-and-paste detection software is available; if this software is available for use, consider using this tool to conduct a national assessment of the appropriate use of copy-and-paste.

Summary Statement

OMI 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 Office of General Counsel has provided a legal review, and the Office of Accountability Review 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.

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I. Introduction

At the direction of the Secretary, the USH asked OMI to assemble and lead a team to investigate complaints lodged with OSC by whistleblowers, a physician and a licensed practical nurse (LPN) at the CBOC, who alleged that the Medical Center engaged in conduct that may constitute a violation of law, rule or regulation, gross mismanagement, and a substantial and specific danger to public health. They described issues regarding inadequate staffing and inaccurate documentation. The VA team conducted a site visit to the Medical Center and CBOC on September 30 through October 2, 2014.

II. Facility Profile

The Medical Center, part of the VISN 5, serves more than 126,000 Veterans in West Virginia, Maryland, Virginia, and Pennsylvania with a comprehensive range of services, including internal medicine, ambulatory surgery, audiology and speech pathology, dental, nursing home, nutrition, podiatry, prosthetics, women's health, mental health, and rehabilitation medicine. It has 559 authorized beds, 69 medical, 178 nursing home care unit, and 312 domiciliary, and oversees 7 CBOCs, including the Fort Detrick CBOC in Frederick, Maryland. The Fort Detrick CBOC offers primary care, mental health, podiatry, occupational therapy, physical therapy, tele-retinal, orthopedic, dermatology, pharmacy and dietician services. During fiscal year (FY) 2013, the CBOC provided care to 3,477 Veterans, for a total of 15,935 outpatient visits.

III. Specific Allegations of the Whistleblowers

1. Martinsburg VAMC and Fort Detrick CBOC leadership failed to address chronic staffing deficiencies at Fort Detrick CBOC, which has adversely affected patients' access to care and resulted in serious risk and harm to patients; and
2. In an effort to achieve performance measures, primary providers use templates to generate patient chart notes that include false and misleading information regarding the care and services provided during patient visits.

IV. Conduct of the Investigation

The VA team consisted of (b)(6) Deputy Medical Inspector; (b)(6) (b)(6) Clinical Program Manager, both from OMI; (b)(6), Subject Matter Expert, PACT Program Manager in the Office of Nursing Services at VA Central Office; and (b)(6); Supervisory HR Specialist for Employee and Labor Relations at the Coatesville VA Medical Center. The team reviewed relevant policies, procedures, reports, memorandums, and additional documents as listed in Attachment A.

VA interviewed both whistleblowers by telephone prior to the site visit, and conducted face-to-face interviews with the following individuals at the Medical Center and the CBOC:

- (b)(6) Chief of Primary Care and Emergency Department Services
- (b)(6), Associate Medical Center Director for Nursing Programs & Education
- (b)(6) Assistant Chief Nursing Service, Ambulatory Care
- (b)(6), CBOC Nurse Manager
- (b)(6) PCMM Coordinator
- (b)(6) PACT Business Manager
- (b)(6), Chief, Medical Administrative Service
- (b)(6), Patient Safety Specialist
- (b)(6), Patient Advocate
- (b)(6) Risk Manager
- (b)(6), CBOC
- (b)(6), CBOC
- (b)(6) CBOC
- (b)(6) CBOC
- (b)(6), CBOC
- (b)(6), CBOC
- (b)(6), CBOC
- (b)(6) CBOC
- (b)(6) Physical Therapist, CBOC
- (b)(6), CBOC Coordinator, CBOC
- (b)(6), MSA, CBOC
- (b)(6), MSA, CBOC
- Veteran A
- Caregiver A

During this site visit, VA held an entrance briefing with Medical Center leaders, then traveled to the CBOC, toured the clinic, and interviewed staff. At the Medical Center, VA completed the remaining interviews and conducted an exit briefing with leadership.

V. Findings, Conclusions, and Recommendations

Allegation 1

Martinsburg VAMC and Fort Detrick CBOC leadership failed to address chronic staffing deficiencies at Fort Detrick CBOC, which has adversely affected patients' access to care and resulted in serious risk and harm to patients.

Findings

The Fort Detrick CBOC provides primary care and numerous specialty care services. Primary care is provided using the PACT model established by VHA in 2009. Per VHA Handbook 1101.10, *VHA PACT Handbook*, the PACT model is intended to provide primary care that is “patient-centered, data driven, continuously improving, team-based, accessible, timely, comprehensive coordinated and provides a continuity of care over time.”¹ Staffing for the PACT must be sufficient to ensure that all Veterans assigned to the patient panel receive appropriate and desired health care. Each PACT serves an average of 1,200 patients, and is supported by a team of staff or “teamlet.” The Handbook recommends that each full time equivalent (FTE) Primary Care Provider (PCP) is to be supported by: an RN Care Manager, an LPN or a Licensed Vocational Nurse, a Health Technician (HT), or Medical Assistant, and an Administrative Associate, known as a Medical Support Assistant (MSA). These staffing requirements apply to Primary Care at the parent facility, as well as at the CBOC. The CBOC operates three PACTs, of which the first two are fully staffed, per the Handbook.

A single HT operates the CBOC’s laboratory services, drawing blood and preparing specimens for transport to the Medical Center for analysis. To provide back-up coverage to the laboratory and clerical support, CBOC leadership hired another HT to fill the MSA position in PACT 3, providing clerical coverage there and back-up coverage for the laboratory in the absence of the primary HT. This HT/MSA has been on military leave since May 2014, and is not expected to return until April 2015. Leadership has not assigned any other staff to cover for this person, nor has it implemented any other coverage plan. The primary HT and the MSA assigned to PACT 2 provide clerical coverage for PACT 3 when possible.

Since leadership assigned only one HT to cover the laboratory, when that individual is absent, a PACT LPN assumes those duties, pulling that person away from PACT duties for up to 6 hours per day. In the 3 months from July 1, 2014, through October 2, 2014, this reassignment of a PACT LPN to the laboratory occurred 13 times. On one occasion, an LPN was even pulled to cover clerical duties at the CBOC front desk. When the LPN from PACT 3 covers the laboratory, that PACT is left without both its MSA and LPN. The LPNs from the other two PACTs assist PACT 3 whenever possible, but according to VHA Handbook 1101.10, “local service level officials accountable for PACTs must establish and implement contingency plans for ensuring patients receive continuity of and access to appropriate primary care during periods of inadequate resources, extended staff absences, staff turnover, understaffing and nature-related events.” The CBOC lacks a contingency plan to ensure adequate coverage of both the laboratory and the PACT 3 clerical position.

In addition to primary care, the CBOC provides mental health, podiatry, occupational and physical therapy, orthopedic, tele-retinal, pharmacy, social work, dietician, and limited onsite radiology services. Each of these specialty clinics and services require

¹ VHA Handbook 11.01.10, VHA Patient Aligned Care Team (PACT) Handbook. February 5, 2014.

both administrative and clinical support, which initially were the responsibility of the PACTs. While primary care enrollment was low enough at first for PACT staff to provide support for these specialty clinics without compromising the care of the existing PACT panel, the increase of clinical enrollment, along with the increase of the number of specialty services made continued PACT staffing impossible. The CBOC has recently hired clinical and support staff for the dermatology and podiatry clinics, and the Medical Center has furnished direct support for the CBOC's orthopedic clinic and physical therapy service.

Per VHA Handbook 1101.02, *PCMM*, "the PCMM is a Veterans Health Information Systems and Technology Architecture (VistA) application that allows facilities to track primary care team staffing and workload. With it, users set up and define health care teams, assign staff to positions within the teams, and assign patients to the PACT." Neither the PCMM Coordinator nor Medical Center leadership performed PCMM data validation on a monthly basis, as required by this Handbook. The PCMM Coordinator was not even aware of staffing issues at the CBOC and had not fully engaged in the process of updating the staffing component in PCMM. In June 2014, a review of documentation of PACT staffing included in the Office of Primary Care's annual PCMM audit revealed deficiencies in accurate documentation, but the Medical Center has yet to address them; from all indications, documented staffing levels in the CBOC do not reflect the actual number of staff available to provide care to PACT patients. The CBOC must accurately document current staffing levels and workload in order to ensure adequate staff is allocated to the PACT.

Medical Center leadership needs accurate staffing levels to determine the most appropriate patient panel size for each PACT provider. Because the documented staffing levels are not accurate, they give the misleading appearance that all the PACTs are fully staffed. The Medical Center continues to count the MSA/HT currently on military leave in PACT staffing, and does not factor in instances of PACT LPNs being pulled to cover the laboratory. In addition, the current PCMM documentation does not take into account the occasions of specialty clinics and services pulling PACT staff for support.

Laboratory tests, such as analysis of blood, urine, and other body fluids for abnormalities or changes help providers diagnose medical conditions, plan or evaluate treatments, and monitor disease states. Providers routinely order them as part of a PACT clinic visit, using the order entry menu in the patient's EHR to list which tests are needed and when they must be done. Once the provider signs the order, the MSA or HT can carry it out.² Providers use the same process to request patient appointments. Both whistleblowers alleged that some orders for laboratory tests and appointments were not completed because of inadequate clerical staffing. VA learned that between November 13, 2013, and April 25, 2014, whistleblower 1 submitted six incident reports,

² "Carrying out orders:" the provider submits orders for appointment and laboratory studies electronically. Next the orders become visible to the MSA or HT in the "Orders" section of the medical record. The MSA or HT then reviews the order, schedules any ordered appointment, and requests laboratory studies. The request for laboratory studies is done as an appointment to the lab and includes the studies ordered by the provider.

and a pharmacist had submitted one, for a total of seven incident reports for seven different patients of orders and appointment requests that had not been performed, even though according to the PCMM, the PACTs were fully staffed during this time. Three incident reports identified follow-up appointments ordered, but not entered in the recall/reminder system for dates 1 year from that of the order. Per VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, staff uses recall/reminder software whenever the requested follow-up appointment date is more than 3 or 4 months in the future.³ Within 4 months of an appointment, staff contacts the patient to remind him or her of the appointment and to provide an opportunity to reschedule it, if need be. In one of these three incidents, laboratory studies were also ordered with the follow-up appointment, but the medical record shows no indication that the studies were ever scheduled. The other four incident reports identified orders for laboratory tests that were never carried out. VA reviewed the medical record of the seven patients and found:

- The provider requested follow-up appointments for January and February 2015 for three patients, but contrary to VHA Directive 2010-027, the appointments were not scheduled at the time ordered.
- The provider ordered laboratory tests for a patient with a history of gout but the orders were not carried out.⁴ The patient, who had not experienced an exacerbation of his gout in the previous 6 months, was taking one medication for its treatment. He desired to resume an additional gout medication, but needed laboratory studies done first. The studies were not performed until 1 month later, after which the provider ordered the second medication. Although the medication was delayed by 1 month, the patient's condition, although chronic, was stable, and the error did not pose a serious threat to his health.
- The provider ordered laboratory studies for one patient with a history of hyperlipidemia and low Vitamin D levels. The orders were not carried out and laboratory studies were performed 6 weeks later; the patient experienced no adverse outcomes as a result of this delay.
- The provider ordered laboratory studies for a patient with mild anemia.⁵ The orders were not carried out and the tests not done. The patient was seen again on April 4, 2014, and the labs were ordered to be done with his upcoming appointment in April 2015. The patient experienced no adverse outcome; and
- The pharmacist filed an incident report on an unfulfilled order, but VA could not find this order in the EHR.

In summary, an order had not been carried out in six of the seven incident reports. Three of the orders requested follow-up appointments for a year later and were not appropriate to schedule, but to be placed in the recall/reminder module, per VHA Directive 2010-027. Three orders for labs were not carried out and resulted in a delay in treatment in one case, but no adverse effects were found in any of the cases.

³ VHA Directive 2012-027, *VHA Scheduling Processes and Procedures*, January 2010.

⁴ Gout: gout is a common, painful form of arthritis caused by a buildup of uric acid crystals in the joints. Uric acid is a breakdown product of purines that are part of many foods we eat. An abnormality in handling uric acid and crystallization of these compounds in joints can cause attacks of painful arthritis. (www.nlm.nih.gov)

⁵ Anemia: Anemia is a condition in which the body does not have enough healthy red blood cells. Red blood cells provide oxygen to body tissues. (www.nlm.nih.gov)

Although the failure to carry out orders is an error that must be addressed, in these cases it did not pose a serious threat to the patient's health. Inadequate staffing is attributed as an underlying cause for this error. At the time of the incidents, each PACT was assigned an MSA, but the MSA/HT for PACT 3 was also responsible for covering the laboratory whenever needed, leaving only two MSAs for the three PACTs. The MSAs were supporting the specialty clinics as well.

Incident reporting is a voluntary patient safety event reporting system that relies on those involved in the event to provide detailed information about the incident.⁶ Incident reports can be generated by staff directly involved in an event or actions leading up to an event. Incident reporting is a form of surveillance for near misses and unsafe conditions. In VHA, incidents are reported using an electronic incident report, which describes what happened, who was involved, and what actions were taken at the time the incident occurred or near miss discovered. Once completed, the report is submitted to the Medical Center's Patient Safety Manager (PSM) as notification of an adverse event or close call. The PSM reviews the report and assigns a SAC, the scores of which reflect the probability and severity of a reported incident: the greater the severity and probability of an occurrence, the higher the SAC score. A score of 1 indicates lowest risk, 2 an intermediate risk, and 3 the highest risk. According to VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, events receiving a SAC score of 1 or 2 "are to be addressed appropriately by the facility." These actions can range from determining that no further action is needed to the imposition of serious investigations. All SAC 3 events undergo an RCA, a structured method used to analyze serious adverse events. The process involves data collection, record review, participant interviews, and reconstruction of the event in question. The RCA team analyzes the sequence of events to determine how and why the event occurred, identifying individual errors and systemic issues. The goal of an RCA is to prevent future harm by eliminating errors that often result in adverse events.⁷ Although none of the incidents reported by the whistleblower or pharmacist warranted an RCA, VA found no evidence that the Medical Center had investigated why seven incidents on similar issues occurred in the CBOC within a 6-month period, nor did VA find any evidence that Medical Center leadership had notified the CBOC Nurse Manager about the incident reports.

Currently, only two MSAs perform clerical duties at the CBOC's front desk, so the majority of incoming telephone calls pass through an automated direction system that gives callers the option to speak with, or leave a message for, the clerk or nurse of each PACT. This "telephone tree" is long and potentially confusing to callers who do not use it frequently; it is not user friendly. We interviewed three waiting patients about the telephone system and found they had no problems with it; however, staff reported numerous verbal complaints from patients about both the telephone system and the inability to speak with a human when calling the CBOC. The team had attempted to phone the clinic several times before our site visit but was never able to speak with any staff member.

⁶ AHRQ: Voluntary Patient Event Reporting. www.psnet.ahrq.gov

⁷ AHRQ: Root Cause Analysis. www.psnet.ahrq.gov

The whistleblowers described a recent incident involving one of their patients who suffered a stroke:

The patient's wife called Fort Detrick CBOC on (b)(6) 2014, when her husband first began exhibiting signs of a possible stroke. She was unable to speak with anyone at the clinic for 2 days, as no one answered the telephone. As the patient's symptoms continued to worsen, she drove him to the clinic on (b)(6) to see whistleblower 1 without an appointment. The whistleblower assessed the patient and immediately admitted him to Martinsburg VAMC, where testing confirmed the diagnosis of a stroke. Had whistleblower 1 been able to see the patient 2 days earlier, when the patient's wife initially attempted to call, he would have prescribed an anticoagulant, such as Plavix, and likely could have prevented the stroke.

VA interviewed the patient's caretaker, who stated that she called the CBOC on three separate occasions in an attempt to speak with a nurse or provider because the patient stated he did not feel well. She was not able to speak with a staff member on any of the three occasions. She states she left a message for the nurse, but did not receive a return call. She drove the patient to the CBOC, and the patient was immediately seen by his provider.

Our review of the EHR revealed that this Veteran, a 58 year-old male, had suffered a stroke on (b)(6) 2014. On (b)(6), 2014, whistleblower 1 evaluated him as a new patient at the CBOC and found that the stroke had left him with right-sided weakness, difficulty rising from a sitting position, and walking independently, although he did not need a cane or crutches. The Veteran also reported difficulty swallowing and trouble with some choking. The whistleblower ordered referrals to physical and speech therapy.

On (b)(6), 2014, the Veteran kept his fifth appointment with the speech therapist at the CBOC. The speech therapist noted in the EHR that the Veteran's speech was much improved with only occasional slurring, and also that his overall mood was improved, although he said that he was not feeling well at the time of the visit. She recommended continuation of the speech therapy treatment plan.

According to the EHR, an RN assessed the Veteran at 2:33 p.m. on (b)(6) 2014, during his unscheduled visit at the CBOC. She noted that he had ill-defined symptoms of "not feeling well," and he stated that he had fallen 5 days before and was experiencing difficulty with mobility and dizziness. His blood pressure and other vital signs were within normal limits. The RN also noted that the Veteran had "difficulty turning and complained of light headedness." She referred the Veteran to whistleblower 1 for further evaluation.

At 2:53 p.m., whistleblower 1 evaluated the Veteran, and noted that he complained of a new, bad headache, blurred vision and arm tingling (side not specified). He also noted that the Veteran was ambulatory without assistance and entered a note on the new-onset, severe headache in a patient with a previous stroke and some nonspecific

fatigue in the EHR. He ordered a computed tomography (CT) scan and instructed the Veteran's wife to drive the patient to the Medical Center's Emergency Department (ED), approximately an hour away, even though emergent care was available closer to the CBOC.

At 7:23 p.m., the Veteran was seen in the Medical Center's ED, where a physician noted that the Veteran's headache had resolved and that these headaches were not unusual for him. The Veteran told the physician that he had developed similar headaches daily for the last year and treats them with acetaminophen. The ED physician also noted that the blurred vision had resolved. Apart from the left arm numbness, the Veteran had no new neurological symptoms since the April 10 stroke. After the CT scan showed a possible new subacute stroke, the ED physician admitted him to the Medical Center for further evaluation and treatment.

At 10:30 p.m., the inpatient attending physician noted that the Veteran's headache and his right arm numbness had resolved. The CT scan showed no acute intracranial abnormality, but did reveal an area of possible infarction of uncertain acuity. The attending physician assessed the Veteran as having right-sided weakness and numbness, and referred him to Neurology to rule out a stroke. The following day at 4:47 p.m., the Medical Center Neurology specialist evaluated the Veteran's acute dizziness, and concluded that in all likelihood, the Veteran had not experienced another stroke. While noting the Veteran's previous history of stroke, he recommended discharge from the hospital when the Veteran's other medical conditions had stabilized. On (b)(6) 2014, the Veteran was discharged from the Medical Center with a diagnosis of recurrent transient ischemic event or stroke. The EHR reflects that the Veteran had improved over the course of this hospitalization. The attending physician recommended that the Veteran continue with his physical and speech therapy.

VA's review of this Veteran's EHR found that the diagnosis of stroke on (b)(6) 2014, was questionable. The Veteran did not present with findings consistent with a new stroke. Headache and dizziness are nonspecific symptoms. The neurologist did not conclude that the Veteran had a stroke, and no examiner documented a permanent change in the Veteran's neurologic condition. It is possible that the Veteran suffered a transient ischemic attack but it did not progress to a stroke. The whistleblower's referral of the Veteran to the Medical Center ED, an hour away by car, suggests that whistleblower 1 did not assess the Veteran's condition as emergent at the time he evaluated him.

In summary, the Veteran's caretaker having difficulty in reaching a clinician at the CBOC did not result in the Veteran's further decline. While the CBOC has safeguards in place for patients unable to reach staff, including instructions for the caller to dial 9-1-1 in an emergency, and allotting time for walk-in appointments in each PACT's daily schedule, it does not have adequate administrative support to ensure incoming calls are consistently answered.

Conclusions for Allegation #1

- VA substantiated that Martinsburg VAMC and Fort Detrick CBOC leadership failed to address chronic staffing deficiencies in Fort Detrick CBOC's PACT, laboratory, and specialty care clinics, which has adversely affected patients' access to care and resulted in risk to patients.
- VA substantiated that current staffing levels at the CBOC are not in compliance with the PACT model per VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook*, and are inadequate to support the PACT model. Staff is supporting specialty clinics and the laboratory in addition to their assigned PACT.
- VA substantiated that current documented staffing levels in the PCMM do not accurately reflect actual staffing, giving the appearance that all PACT teams are fully staffed.
- VA substantiated that staff absences are not appropriately provided for.
- VA substantiated that CBOC administrative staff did not carry out some orders for laboratory tests and requests for future appointments. Whistleblower 1 submitted six incident reports on six orders that were not carried out.
- VA substantiated that although none of the incidents reported by whistleblower 1 or the pharmacist warranted an RCA, the Medical Center neither investigated the multiple incidents occurring in the CBOC over a 6-month period nor informed the CBOC Nurse Manager of the reports.
- VA substantiated that the CBOC does not have adequate administrative staff to consistently answer the phone and its telephone system is not user friendly.
- VA substantiated that a Veteran's caretaker was not able to speak with a staff member when she telephoned the CBOC on three separate occasions.
- VA did not substantiate that the Veteran experienced a preventable stroke and further decline as a result of not being able to reach any clinicians via telephone at the CBOC for medical advice.

Recommendations to the Medical Center

1. Develop a contingency plan to ensure adequate coverage during staff absences at the CBOC.
2. Document PACT staffing correctly in the PCMM. Take corrective action addressing the deficiencies identified in the PCMM audit conducted in (b)(6) 2014.

3. Make sure specialty clinics have adequate administrative and clinical support that is not provided by PACT staff. Evaluate staffing needs and continue to fill vacancies as indicated.
4. Provide retraining about order verification to PACT clerical staff. Monitor for compliance and address noncompliance as indicated.
5. Conduct an audit of unverified orders for the CBOC for the previous 3 months, and determine if any patient harm occurred as a result of unverified orders. If patient harm occurred, make sure the Veteran is receiving care, and is informed of any adverse event if required by VHA Handbook 1004.8, Disclosure of Adverse Events to Patients.
6. Develop and implement a process for following up on incident reports that do not warrant an RCA. As the CBOC person charged with reviewing and addressing each incident as indicated, the Nurse Manager must have access to these reports.
7. Rectify the problems with the telephone system to make it more user friendly.

Recommendation to VISN 5

8. VISN 5 should conduct an organizational assessment to identify the basis for communication breakdowns between the Medical Center, the CBOC and HR around staffing issues impacting the CBOC's PACTs, laboratory, primary care, and specialty care clinics. This assessment should determine the root cause of the breakdowns and establish a communication improvement plan to address the following: coverage for military leave, vacancies, and staffing needs to meet the demand for increased services.

Recommendation to VHA

9. Assess the need for tracking of Safety Assessment Code (1) incidents. If a need exists to track these, ensure they are tracked in a uniform manner across the system.

Allegation #2

In an effort to achieve performance measures, primary providers use templates to generate patient chart notes that include false and misleading information regarding the care and services provided during patient visits.

Findings

Under 44 United States Code § 3102 (1), Establishment of Program of Management, and VHA Handbook 1907.01, *Health Information Management and Health Records*, "VHA, by statute, must maintain complete, accurate, timely, clinically-pertinent, and

readily-accessible patient health records, which contain sufficient recorded information to serve as a basis to plan patient care, support diagnoses, warrant treatment, measure outcomes, support education, research, and facilitate performance improvement processes and legal requirements.” In order to provide the most comprehensive and appropriate care, information documented in the patient’s EHR must be an accurate reflection of assessments, diagnostic findings, and treatments.

Whistleblower 1 alleged that PCPs’ notes include false and misleading information regarding the care and services provided during patient visits, and at times examinations that were documented, were, in fact, never performed. Whistleblower 2 provided VA with the names of six patients and the dates of notes that included false and misleading patient documentation. Both alleged that PACT providers’ template notes are duplicates of notes from previous visits and do not accurately reflect examinations performed or findings.

The EHR contains all of the Veteran’s clinical information: orders, clinical reports, laboratory reports, progress notes, etc. Within the EHR, some providers use template notes to permit rapid entry of information through the use of radio buttons, check boxes, and free text; only the selections made within the dialog template appear in the note. Regardless of whether or not a template is used for composing notes, the information documented in the notes must actively reflect any examinations performed and findings from the examination. VA reviewed the EHRs of the six patients provided. These notes were entered by three different providers, one of whom was named in an allegation made by whistleblower 2. VA found that the individual notes were not the same, indicating different chief complaints, assessments, and planned treatments. However, during VA’s interview regarding telephone access, a Veteran stated that her medical record was inaccurate: while reviewing it, she noted that her PACT provider had documented two examinations that had not occurred. We reviewed this Veteran’s EHR and found that the provider had indeed documented an examination that did not take place. The author of the note was also a provider named in whistleblower 2’s allegation.

Conclusions for Allegation #2

- VA did not substantiate record copying in the EHRs of the six Veterans named by whistleblower 2.
- VA substantiated that a PACT provider had documented examinations not performed.

Recommendations to the Medical Center

10. Review 3 months of EHRs entered by the PACT provider named by the Veteran for any evidence of false data. If evidenced of false data is found, take the appropriate disciplinary and oversight actions.

11. Review 3 months of EHRs entered by the other CBOC PACT providers for evidence of false data. If evidenced of false data is found, take the appropriate disciplinary and oversight actions.
12. Provide additional training to providers on VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014, regarding the requirement for accurate documentation.

Recommendation to VHA

13. Consider exploring if copy-and-paste detection software is available; if this software is available for use, consider using this tool to conduct a national assessment of the appropriate use of copy and paste.

VI. Summary Statement

OMI 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 Office of General Counsel has provided a legal review, and the Office of Accountability Review 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 by VA

1. CBOC RN Care Coordinator II and III Functional Statements
2. CBOC LPN GS-6 Functional Statement
3. CBOC Staffing Levels from August 2012–September 2014
4. CBOC PACT Staffing Levels (current)
5. CBOC Time and Attendance Reports
6. CBOC Telephone Usage Report
7. CBOC Clinical Pertinence Template and Reports of Findings
8. CBOC Organizational Chart
9. CBOC Nursing Meeting Minutes from March 2013–September 2014
10. Electronic Incident Reports about the CBOC filed from December 2013–July 2014
11. Medical Center Primary Care Meeting Minutes, November 2013–August 2014
12. MSA Functional Statement
13. Physician Functional Statement
14. Department of Veterans Affairs, VHA Handbook 1101.10, *VHA Patient Aligned Care Team (PACT)*. February 5, 2014.
15. Department of Veterans Affairs, VHA Directive 2012-027, *VHA Scheduling Processes and Procedures*. January 2010
16. Department of Veterans Affairs, VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*. March 4, 2011.
17. Department of Veterans Affairs, VHA Handbook 1907.01, *Health Information Management and Health Records*. July 22, 2014.
18. Department of Veterans Affairs, VHA Handbook 1101.02, *Primary Care Management Module (PCCM)*. April 12, 2009.