Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Oversight Review of Specialty Service Issues at the VA Montana Health Care System, Fort Harrison, Montana

Report No. 08-02992-162

July 8, 2009

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations

Telephone: 1-800-488-8244 between 8:30AM and 4PM Eastern Time, Monday through Friday, excluding Federal holidays

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Contents

Executive Summary

The VA Office of Inspector General reviewed actions taken by the Veterans Health Administration (VHA) to address allegations that a physician at a VA medical center was providing substandard care and engaging in improper medical record documentation practices.

We found that upon receipt of the allegations, the medical center and Veterans Integrated Service Network (VISN) took several immediate actions including placing the subject physician on administrative leave and convening an Administrative Board of Investigation (ABI). An ABI team site visit ensued soon thereafter, during which testimony from relevant VA staff was taken and medical records examined.

While the ABI did raise patient care concerns, it largely did not substantiate the allegations. However, in the interim between the empanelling of the ABI team and the completion of its work, additional allegations of poor care on the part of the same physician were made. In the face of these new case allegations, as well as the patient care concerns that the ABI did raise, the VISN concluded that the ABI was not determinative.

Accordingly, VISN and medical center managers arranged to have one of the three cases that the ABI found to show deficient care, as well as newly identified cases, reviewed by an external, non-VA physician in the same specialty as the subject physician. This reviewer identified serious quality of care deficiencies by the subject physician. The subject physician rebutted the external peer reviewer's conclusions. However, the external peer reviewer stood by the key findings and conclusions made. The VISN tracked the process and convened its own peer review committee to adjudicate the matter. This committee largely substantiated the findings and conclusions of the external peer reviewer. The subject physician was separated from employment at the medical center.

Other concerns identified and issues addressed in the course of this oversight review included that a procedure was not scheduled timely, unclear or inaccurate testimony as to when the subject physician's service chief first learned of allegations of substandard care, use of the "copy and paste" function in creating medical record chart notes, equipment purchases, and allegations that several medical records "signature blocks" were deleted from progress notes. Finally, in the course of performing this oversight review, numerous additional concerns regarding the provision of care to veterans were identified beyond the allegation about a single physician. These concerns referred to the overall operation of a clinical service.

Conclusions

We concluded that VISN and medical center managers complied with existing VHA policy in taking the actions described in this oversight review. We concluded that the VISN and the medical center were initially impeded in this task by an ABI process and product that did not sufficiently address the complainant's allegations.

In view of remaining issues, we also concluded that a panel of relevant specialists and administrators needs to perform a comprehensive review of care in the specialty referenced in this report and for veterans served by the medical center.

Recommendations

Acting Under Secretary for Health

Recommendation 1. We recommended that the Acting Under Secretary for Health empanel a team of relevant specialists and administrators to perform a comprehensive review of all aspects of the referenced specialty care for veterans served by the medical center.

VISN 19 Director

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director completes a medical record review of all cases managed by the subject physician to determine whether the care provided met standards for quality.

Recommendation 3. We recommended that the VISN Director ensure that patients seen only by the subject physician be offered new (current) examinations at a VA facility or on a fee-basis arrangement.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires procedures to be completed in a timely fashion.

Comments

All management officials concurred with the findings and recommendations and submitted appropriate implementation plans. (See Appendixes A–C beginning on page 14 for the text of their comments). We will follow up until all actions are complete.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) reviewed actions taken by the Veterans Health Administration (VHA) to address allegations that a physician at the Montana Health Care System, Fort Harrison, Montana (medical center) was providing substandard care and engaging in improper medical record documentation practices.

This review describes actions taken by VA Central Office (VACO), the Veterans Integrated Service Network (VISN) 19, and medical center managers to address and respond to the allegations and makes findings relative to these actions.

Background and Initial Chronology – Allegations of Substandard Care

In a letter dated April 13, 2008, a complainant wrote to VA's OIG alleging that a medical center staff physician was providing poor quality of care to veterans and engaging in medical record documentation irregularities related to these episodes of care. The complainant alleged that this physician (hereafter referred to as the "subject physician") had practiced in an incompetent manner and may not have performed appropriate physical examinations. The complainant also alleged that examinations not properly performed were nonetheless documented to have been performed and that misdiagnoses appeared "to arise from less than adequate exams" leading to "delays in treatment and then to subsequent prolonged suffering … for the patients involved." The complainant further asserted, "it is startling to find that patients who have been followed, sometimes for years without apparent … pathology, suddenly 'acutely manifest' an advanced form of their previously quiescent or undiagnosed malady. Only after referral to another physician or following a [type of examination] do [the subject physician's] exam findings change to reflect more accurately the true … conditions afflicting [the subject physician's] patients." The complainant stated, "At best I believe that you will find gross incompetence on the part of [the subject physician]. At worst, some cases will lead you to believe that sham … examinations are performed, and therefore fraud is taking place."

In support the allegations, the complainant provided the OIG with excerpts from the medical records of 28 VA patients.

Upon receipt of these allegations on April 17, 2008, two senior OHI physicians reviewed the allegations and the supporting documentation, contacted the complainant, and brought the allegations to the immediate attention of senior officials in VACO in Washington, DC, as well as to the VISN Director. The VISN requested to review the allegations.

Scope and Methodology

This review enumerates and comments upon events subsequent to the case referral to the VISN. Also, in the course of monitoring this case, additional allegations were brought to OHI's attention. These allegations primarily pertained to care and services provide by the medical center but also related to its management.

An OHI physician and regional office director visited the medical center in the fall of 2008. Appropriate medical center staff physicians were interviewed. Additionally, we interviewed senior medical center managers, including the relevant Service Chief, an Associate Chief of Staff, the medical center Chief of Staff, and the medical center Director.

We interviewed relevant medical center personnel involved in the provision of care, including present and former technicians. We also interviewed community based outpatient clinic (CBOC) staff distant from the medical center who support the applicable clinical program.

In response to the complainant's April 13, 2008, letter, the VISN empanelled an Administrative Board of Investigation (ABI). The ABI team reviewed alleged cases of deficient care by the subject physician. In addition, cases of allegedly deficient care were reviewed by a private sector firm that provides medical review services.

We reviewed the testimony obtained under oath by the ABI as well as the ABI's final report and supporting exhibits. We interviewed each of the three members who sat on the ABI and the VISN's ABI coordinator/facilitator. Also, we interviewed or discussed the case with senior VISN officials, including the Chief Medical Officer (CMO), the VISN Deputy Director, and the VISN Director. We evaluated patient medical records, peer review results, clinic workload data, and correspondence between medical center staff and the subject physician.

We reviewed VA Handbook 0700, *Administrative Investigations*, July 31, 2002, and VHA Handbook 1907.1, *Health Information Management and Health Records*, August 25, 2006. We visited the relevant areas of the medical center and reviewed relevant expenditures.

On March 13, 2009, the medical center terminated the subject physician from VA employment. We reviewed the personnel documents related to this action, including the proposed letter of separation; the subject physician's reply, which included a rebuttal to findings of provision of substandard care; and a rebuttal by the private sector peer review firm to the subject physician's rebuttal. Because one assertion by the subject physician in defense of the charge of provision of substandard care was that some veterans' care was split between the subject physician and private sector, non-VA providers, we reviewed VHA Directive 2002-074, *VHA National Dual Care Policy*, November 20, 2002.

In light of the ultimate finding by the VISN that substandard care had occurred, we requested all plans made to ensure appropriate follow-up and/or re-evaluation of veterans who had received care related to this issue at the medical center.

This inspection was conducted in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results and Conclusions

Issue 1: Initial VISN and Medical Center Management Actions

Upon receipt of the complainant's April 13, 2008, letter, the VISN took several immediate actions. It directed that the subject physician be placed on administrative leave with computer access terminated. On April 21, the VISN Deputy Director arrived at the medical center to perform an assessment of the situation and to ascertain the next steps required. On April 23, the VISN CMO arrived at the medical center to perform preliminary case reviews and to ascertain the next steps required.

The VISN Director decided to convene an ABI. By May 2, 2008, the VISN Director had recruited two board certified physicians in the same specialty as the subject physician and an ABI chairperson who had significant ABI experience. The ABI's charge from the VISN included the following:

> The ABI shall conduct a thorough investigation into the facts and circumstances regarding the allegations that [the subject physician] has:
>
> (1) failed to properly conduct patient examinations;
>
> (2) entered false information into patient medical records to reflect performance of examinations that, in reality, were not conducted; and
>
> (3) documented information from the records of prior patient visits to make it appear as though these same examinations were conducted during subsequent visits.

From May 21–23, 2008, the ABI team visited the medical center. The ABI took testimony from relevant individuals, including medical center staff in the same specialty as the subject physician, other medical staff involved in the provision of the relevant specialty care, and senior medical center management officials. The team also toured the medical center and examined medical records and other relevant data.

Issue 1: Findings Regarding Initial VISN and Medical Center Management Actions

We found that the VISN complied with existing VHA policy in taking the actions described above. Its actions were prompt and aggressive and demonstrated concern appropriate to the serious allegations made.

Issue 2: ABI Results

In the course of its investigation, the ABI team was given an additional 11 cases of alleged substandard care. It also heard testimony concerning issues not in the ABI charge letter. These additional issues included alleged excess waiting times and concerns about the comportment of a medical center physician.

On July 18, 2008, the ABI issued its report. The report was accompanied by 15 exhibits, primarily transcripts of testimony. In addition to exhibits containing testimony, one exhibit consisted of a 4-page document that was a spreadsheet of review comments pertaining to the initial 28 cases provided to the OIG by the complainant, as well as to the additional 11 problematic cases brought to the ABI's attention while it was onsite. No comprehensive case reviews were produced by the ABI.

The ABI concluded:

> 1: With regard to the allegation of failure to properly conduct patient examinations, it is the finding of this investigative board that there was no failure to properly conduct patient examinations on the part of [the subject physician].
>
> 2: With regard to the allegation that [the subject physician] entered false information into the patient medical record to reflect performance of examinations that, in reality, were not conducted, it is the finding of this investigative board that false information was not entered into patient medical records.
>
> 3: With regard to the allegation that [the subject physician] has documented information from the records of prior patient visits to make it appear as though these same examinations were conducted during subsequent visits, it is the finding of this investigative board that there is no evidence to support this.

In the body of its report, the ABI noted: "Of the 38 cases reviewed,[1] 31 (82%) were found to be without evidence of improper patient examination." It found that "Four records (10%) were found to have incomplete documentation by [the subject physician]. Incomplete or "scant" documentation is not conclusive evidence that a proper patient - examination was not performed." It found that "Three records (8%) were found to have quality of care issues. All appear to be missed diagnoses by [the subject physician]."

[1] There were 28 original cases and 11 additional cases; 1 case did not have sufficient data to review. Thus there were

Issue 2: Findings Regarding the ABI and ABI Results

We found that confusion, or a disconnect, existed between the ABI process, its results, and the apparent intentions of the VISN. As noted in the Introduction section of this report, the central issue that the complainant's April 13 letter raises is that the subject physician was not practicing in a safe or competent manner. Consider the complainant's statement, "At best I believe that you will find gross incompetence on the part of [the subject physician]. At worst, some cases will lead you to believe that sham … examinations are performed, and therefore fraud is taking place."

However, the ABI charge was not explicit in assigning the responsibility to make such a determination to the ABI. This created frustration on the part of the ABI team, which testified that it was not assigned to assess the quality of care of the subject physician. This also created frustration on the part of VISN officials who had hoped for a more comprehensive review product.

This disconnect was brought home after, as a direct result of the ABI report, the subject physician was returned to duty. In fact, as subsequent events soon revealed, the complainant's core allegation of substandard practice had merit.

OHI also had other concerns regarding the ABI, specifically pertaining to impartiality. In our review of ABI transcripts, there appeared to be inappropriate questioning, directed at the complainant, suggestive of bias. The complainant told OHI that his interview with the ABI was adversarial, describing it as intimidating and uncomfortable.

VA Handbook 0700 states that among the "Duties of Members Appointed to Administrative Investigation Boards," is that of "maintaining objectivity, impartiality, and professionalism, both in fact, and in appearance." The transcripts we reviewed and our interviews with ABI members led us to find that this did not occur. The consequences were not simply a flawed proceeding. Rather, this appeared to affect the ABI's ability to address the critical case allegations of whether or not there was a pattern of substandard care and inappropriate medical record documentation by the subject physician. Finally, resolution of the case was seriously delayed.

Issue 3: Medical Center and VISN Initial Actions Subsequent to the ABI

The ABI report was sent to the medical center Director with instructions that the report be reviewed and a proposed action plan be submitted for approval by the VISN. On July 10, 2008, the medical center proposed an action plan. Based upon guidance from the VISN, the action plan was revised and articulated in a memorandum dated July 17, 2008, proposing and/or noting that that the "Chief of the [applicable] Service receive a Letter of Counseling for not taking immediate action on the issues brought forward to him;" that "a facility policy covering the pasting of notes into CPRS charts has been developed and

implemented;" that "mandatory training is being done on the proper use of pasted notes in CPRS;" and that "given the finding of no fault on the part of [the subject physician], that he will be returned to duty immediately." The plan also noted, "It is apparent that the environment in the [Service] is not a fruitful one." Also, "to remove any doubt of quality of care, random cases from [the subject physician] will be reviewed for accuracy of testing and diagnosis by Quality Management. A 100% peer review of all … will be done for one quarter following his return. If no deviations are found, [the subject physician] will return to the normal peer review process."

On July 21, the medical center informed the subject physician:

> You have been approved to return to duty. The Administrative Board of Investigation has completed its work. In reviewing the charges the Board found
>
> 1. No failure to properly conduct patient examinations.
>
> 2. No false information was entered into patient medical records.
>
> 3. No evidence was found that information from prior visits was used to make it appear that a subsequent visit occurred.
>
> The ABI in its investigation did not substantiate the above three charges.
>
> However, upon review by the ABI of the 39 cases submitted as evidence against you, three cases were found to have a misdiagnosis. Also in some of the cases the documentation could have been improved.

The medical center also informed the subject physician that the above "raises our concern as we are striving to provide the best care to our veteran. In this vein, we feel it necessary to complete a 100% peer review of your … cases over the next quarter to assure patient care quality. If after that time, we find no deviations, we will return to the currently proposed quality management peer review mandated for all providers within the [applicable] service." Additionally, due to new allegations about the subject physician's care, the subject physician was limited in his duties.

On August 18, 2008, the subject physician was returned to modified duty at the medical center.

Issue 3: Findings Regarding VISN Initial Actions Subsequent to ABI

We found that the VISN's proposed actions relative to the subject physician were consistent with the ABI's findings and conclusions.

Issue 4: VISN Additional Actions Subsequent to ABI

VISN officials told OHI that they were concerned about the 8 percent of cases that the ABI noted to have quality of care issues. Furthermore, as other medical center staff physicians began seeing many of the subject physician's patients, new allegations of poor quality of care on the part of the subject physician were made.

Accordingly, VISN and medical center managers arranged to have one of the three cases that the ABI found to show deficient care, as well as seven newly identified cases, reviewed by an external, non-VA physician in the same specialty as the subject physician. In late August and early September 2008, medical records of these eight cases were sent to a private sector firm that provides medical peer review services.

On September 16, 2008, medical center management again decided to remove the subject physician from duty, placing this physician again on administrative leave.

In the time period August 18–September 16, 2008, the subject physician had read imaging studies but did not see any patients. A VISN and medical center mandated oversight review of these imaging study readings revealed no serious problems on the part of the subject physician.

Issue 4: Findings Regarding VISN Additional Actions Subsequent to ABI

We found that VISN officials took appropriate and aggressive actions in light of new allegations that surfaced in the aftermath of the ABI process.

Issue 5: External Peer Review and Subsequent Events

The private sector medical peer review firm reported back on November 19, 2008. It found serious quality of care deficiencies by the subject physician in seven of the eight cases it reviewed.

Typical findings included lack of follow-up, delay in diagnosis, and inadequate medical record documentation. The private sector medical peer review firm summarized by noting that:

> [A] pattern in the care delivered to these patients at the VA by [the subject physician] that is below the standard. On several of the patients there has been lack of examination and incomplete examination of patients. [There is] a pattern of inappropriate [examination] … There is a pattern of missing critical clinical signs….

The private sector medical peer review firm further noted, "*All of these patterns have led to incorrect diagnosis and delay of diagnosis of patients, leading to permanent impairment … in several of these patients.*" [Emphasis added.]

The subject physician was given the opportunity to rebut the above findings. On January 9, 2009, the subject physician submitted a detailed case-by-case rebuttal to the medical center. This case-by-case rebuttal was forwarded to the private sector medical peer review firm.

On March 4, 2009, the private sector medical peer review firm provided a rebuttal to the subject physician's rebuttal. The private sector medical peer review firm stood by the key elements of its findings and conclusions as elucidated in its November 19, 2008, report.

The VISN tracked the process. It had the conflicting reviews evaluated by a VISN peer review committee, which included a physician in the same specialty as the subject physician but from anther medical center. This committee largely substantiated the findings and conclusions of the November 19 private sector medical peer review firm reviews. Further, in that part of the subject physician's defense to the charge of provision of substandard care was that some veterans' care was split between the subject physician and private sector, non-VA providers, the cases were reviewed in the context of VHA Directive 2002-074, *VHA National Dual Care Policy*. It was determined that the mix of VA and private sector care did not abrogate key clinical responsibilities of the subject physician, such as the necessity to document proper examinations in the medical record.

On March 13, 2009, the subject physician was separated from employment at the medical center due to not meeting standards of care.

Issue 5: Findings Regarding External Peer Review and Subsequent Events

OHI found that VISN officials took appropriate and aggressive actions in light of new allegations that surfaced in the aftermath of the ABI process.

Issue 6: Other Issues

A. Procedure Delays

We found that a procedure was not scheduled timely. As of October 20, 2008, there were 118 patients on a waiting list for the applicable procedure. We found that at the current rate of performing this procedure, it would take more than 7 months to clear the existing waiting list. Furthermore, this calculation does not include new patients referred for this procedure who are being added to the waiting list.

B. Testimony of a Service Chief

A Service Chief provided inaccurate testimony as to when he first learned about quality of care concerns. This chief told OHI that he first learned other providers had concerns about the subject physician's provision of care in March 2008. He reported that another physician stopped him in the hallway and showed him a chart containing clinical information that purported to identify poor care and that this physician had more examples of poor care on the part of the subject physician. The chief reported that he told the physician to provide patient names and social security numbers to support the allegations; however, no list was forthcoming.

Despite the chief's attestation to OHI, we have reviewed an e-mail reflecting that he was advised by a provider in August 2007 of concerns about the subject physician's clinical competency.

C. Use of "Copy and Paste" Function

The medical center was not monitoring use of the "copy and paste" function, as required by VHA. The ABI exonerated the subject physician of wrongdoing relative to the "copy and paste" allegation. Copying and pasting was a routine practice among providers at the medical center. After receipt of this complaint, the medical center developed and implemented a policy providing guidance to providers on the acceptable use of "copy and paste." However, we found that the Medical Record Review Committee (MRRC) did not monitor the use of the "copy and paste" function.

The "copy and paste" function allows providers to select and copy data and text documented in the medical record during previous patient encounters and paste it into a current progress note. "Copy and paste" is routinely used by providers when information will not change from one visit to the next (for example, the patient had an appendectomy in 1981). However, if not used cautiously, copying and pasting could result in duplicative and confusing notes. VHA Handbook 1907.01 requires monitoring of copying and pasting in the electronic medical record to assure that the function is used appropriately. Managers told us that after our visit, the MRRC began monitoring this function.

D. Duplicate Clinic Equipment

Equipment purchases are made at the discretion of medical center and VISN managers. With regard to alleged wasteful equipment expenditures, we were told that these purchases were intended to outfit a new clinic section and to replace old equipment. Overall, we concluded that medical center managers made a reasonable decision to purchase new equipment for a clinic.

E. Altered Medical Record

Allegations were made to OHI that several medical records "signature blocks" were deleted from two separate progress notes.

We confirmed that a medical center staff member forwarded two progress notes of two patients to several other medical center staff. This was said to be in order to alert medical center managers of poor care by the subject physician delivered to these two patients. The CPRS allows providers to alert other relevant medical center staff of important issues in a patient's care. The other members of the team electronically sign the document acknowledging their receipt of the information.

The aforementioned medical center staff member had printed out a copy of the notes at the time they were completed. The first note reflected signature blocks for several individuals, including the relevant Service Chief and the administrative assistant to the COS (AA/COS). The second note also reflected multiple signature blocks, including one for the Medical Center Director. At the time of initial printing, most of the signature blocks were still "awaiting signature." The following month, the medical center staff member reprinted the notes, which no longer showed the signature blocks for the Service Chief, the AA/COS, or the Medical Center Director.

The Privacy Act Officer advised us that the signature blocks had been removed because the individuals copied were either not in the clinical chain of command or were superfluous to the process (such as the AA/COS). VHA Handbook 1907.1 provides guidance related to the editing, amending, retracting, or deleting of progress notes. It does not specifically prohibit deletion of signature blocks by designated staff.

Conclusions

We found that VISN and medical center managers complied with existing VHA policy in taking the actions described in this oversight review. They took appropriate and aggressive actions to ascertain the validity of serious allegations made to the OIG on April 13, 2008, and of ongoing, related allegations of substandard care and documentation processes by a medical center physician.

We concluded that the VISN and the medical center were initially impeded in this task by an ABI process and product that did not sufficiently address the complainant's allegations.

Finally, in the course of performing this oversight review, numerous additional concerns regarding the provision of care to veterans were identified. These included but were not limited to:

- Medical center management's receptivity to input by current staff.

- Medical center staff receptivity to supervision.
- Scheduling.
- Workload assignments.
- Structure of care delivery.
- Appropriateness of recruiting goals – types of staff, locations, etc.
- Professional issues – communication, mutual respect, etc.

OHI takes no position as to where the truth lies for each and every allegation, accusation, and counter accusation. What is apparent is that a suboptimal environment for the provision of some care to medical center patients exists. This can only be to the detriment of patient care.

We concluded that a panel of relevant specialists and administrators needs to perform a comprehensive review of care in the specialty referenced in this report and for veterans served by the medical center.

Recommendations

Acting Under Secretary for Health

Recommendation 1. We recommended that the Acting Under Secretary for Health empanel a team of relevant specialists and administrators to perform a comprehensive review of all aspects of the referenced specialty care for veterans served by the medical center.

VISN 19 Director

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director completes a medical record review of all cases managed by the subject physician to determine whether the care provided met standards for quality.

Recommendation 3. We recommended that the VISN Director ensure that patients seen only by the subject physician be offered new (current) examinations at a VA facility or on a fee-basis arrangement.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires procedures to be completed in a timely fashion.

Comments

The Acting Under Secretary for Health and the VISN and Medical Center Directors concurred with the findings and recommendations of this oversight review and submitted acceptable improvement plans to implement the recommendations. (See Appendixes A–C beginning on page 13 for these comments.) We will follow up on all corrective actions until the plans have been fully implemented.

Appendix A

Acting Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: June 4, 2009

From: Acting Under Secretary for Health (10)

Subject: OIG Draft Report: **Healthcare Inspection, Oversight Review of [Specialty Service] Issues at the VA Montana Health Care System, Fort Harrison, Montana** (WebCIMS 429249)

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the findings of this investigation, and while I was pleased to note that both facility and Veterans Integrated Service Network managers took appropriate and aggressive actions to validate the reported allegations, I was nevertheless concerned with your other findings about the delivery of high quality [specialty] care to our Veterans in Montana. Under separate cover, you have been provided with the Network response to your recommendations, and I am assured that appropriate actions have been taken to rectify this situation.

2. I also concur with your recommendation that I empanel a team of qualified clinicians and administrators to perform a comprehensive review of all aspects of [specialty] care for Veterans served by the VA Montana Health Care System. Program managers from the Offices of the Deputy Under Secretary for Health for Operations and Management and Patient Care Services, have already identified potential members for the team, and are developing a proposed review strategy. It is anticipated that the review will be completed by the end of June 2009. The findings and recommendations of this review group will be carefully considered, and corrective actions will be initiated as necessary.

3. Thank you for the opportunity to respond to this report. If additional information is required, please have a member of your staff contact Margaret M. Seleski, Director, Management Review Service at 461-8470.

(original signed by:)

Gerald M. Cross, MD, FAAFP

Attachment

Acting Under Secretary for Health's Comments to Office of Inspector General's Report

The following comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendation

1. We recommend that the Acting Under Secretary for Health empanel a team of [relevant specialists] and administrators to perform a comprehensive review of all aspects of [the referenced specialty] care for veterans served by the VA Montana Health Care System

Concur

The Office of the Deputy Under Secretary for Health for Operations and Management, in conjunction with the Office of Patient Care Services, has initiated plans to convene a review team of qualified professionals to perform a comprehensive assessment of [specialty] care for Veterans served by the VA Montana Health Care System. The review will be completed by the end of June 2009.

In Process June 30, 2009

Appendix B

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 14, 2009

From: Director, Rocky Mountain Network (10N19)

Subject: Healthcare Inspection – Oversight Review of [Specialty Service] Issues at the VA Montana Health Care System, Fort Harrison, MT

To: Under Secretary for Health

Thru: Deputy Under Secretary for Health for Operations and Management (10N)

Attached are the responses from VA Montana Health Care System to the recommendations in the Draft Healthcare Inspection Report on Oversight Review of [Specialty Service] Issues. I concur on all of the responses and actions.

If you have any additional questions, please contact me or Ms. Susan Curtis at (303)-756-9279.

Glen W. Grippen, FACHE

Appendix C

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 14, 2009

From: Director, VA Montana Health Care System (436/00)

Subject: Healthcare Inspection – Oversight Review of [Specialty Service] Issues at the VA Montana Health Care System, Fort Harrison, MT

To: Director, VA Rocky Mountain Network (10N19)

Attached are the recommendations and responses from VA Montana Health Care System.

If you have any questions, please contact me at (406) 447-7900.

Joseph Underkofler

System Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommend that the Acting Under Secretary for Health empanel a team of [relevant specialists] and administrators to perform a comprehensive review of all aspects of [the relevant specialty] care for veterans served by the VAMHCS.

Concur

Recommendation 2. We recommend that the VISN Director ensure that the VAMHCS Director completes a medical record review of all cases managed by the subject [physician] to determine whether the care provided met standards for quality.

Concur – The subject [physician] saw 5,879 Veterans during his tenure at the VAMHCS. VAMHCS has developed a plan in concurrence with Drs. Daigh and Wesley of the OIG and Dr. Anderson, VISN 19 CMO to review all care provided to these veterans. There will be a 100% evaluation by clinical staff of all cases seen by this provider. Those cases displaying any progressive [disease] will have a complete medical record review and a potential peer review. All patients identified with progressive [disease] that have not received care from a VHA or private [specialty] care specialist will be provided urgent [specialty] care evaluation in the manner outlined in Recommendation 3.

Recommendation 3. We recommend that the VISN Director ensure that patients seen only by the subject [physician] be offered new (current) [specialty] examinations at a VA facility or on a fee-basis arrangement.

Concur – As per the response to Recommendation 2, in concurrence with the OIG and VISN, VAMHCS will review all cases seen by this provider to determine any need for follow-up care. VAMHCS has done a thorough review of all cases seen within past year. There were 1,173 Veterans seen. Of these cases, 359 had already received follow-up care by another VAMHCS [physician]. The remaining 814 Veterans identified were prioritized into three categories (Category 1 – [potentially serious, progressive condition]; Category 2 – [less serious]; Category 3 – … other self-limiting issues).

There were 177 Veterans categorized into Category 1 were offered appointments either at the VAMHCS or via fee-basis. Ten of the Veterans were deceased, 131 Veterans have been contacted and 36 are still in the process of being contacted by the facility via multiple attempts including certified letters. Of the 131 that have been contacted, all but 12 have either had their follow-up completed or are scheduled for that care. The remaining 12 have not yet decided what they would like to do.

The Veterans in Category 2 have all either been seen by another [medical center physician] or have scheduled appointments.

The Veterans in Category 3 will wait for their regularly scheduled appointments or self-referrals.

Recommendation 4. We recommend that the VISN Director ensure that the VAMHCS Director requires [procedures] to be completed in a timely fashion.

Concur – VAMHCS will proceed with fee-basis referrals for the current backlog of [procedures]. They have hired an additional 0.7 [specialty physician] for the Missoula CBOC and are recruiting for a 1.0 [specialty physician] at the Billings CBOC. These additions should allow the system to complete [procedures] in a timely manner.

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	George B. Wesley, MD 202-461-4705
Acknowledgments	Victoria H. Coates

Appendix E

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Rocky Mountain Network (10N19)
Director, Fort Harrison VA Medical Center (436/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
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Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senators: Sen. Max Baucus, Sen. Jon Tester
Representative: Rep. Dennis Rehberg

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