DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Facility Leaders Provided Oversight of a Physician in Fellowship Training at VA Sierra Nevada Health Care System in Reno

HEALTHCARE INSPECTION | REPORT #21-02070-265 | SEPTEMBER 22, 2021

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the oversight and performance of a physician in fellowship training (subject physician) at the VA Sierra Nevada Health Care System in Reno (facility).[1]

In early 2021, the Ontario Provincial Police, Canada, arrested the subject physician at a hospital in Canada, for the alleged murder of a patient. The subject physician participated in a geriatric fellowship at the facility and the affiliated institution, University of Nevada, Reno (UNR), from early fall 2018 through early fall 2019. As part of the fellowship, the subject physician provided care to patients in multiple care settings at the facility.[2]

The OIG first learned of the subject physician's arrest, through a report from a confidential complainant to the OIG Hotline. The OIG initiated an inspection to perform an independent review of the quality of care provided by the subject physician, assess the facility and Veterans Integrated Service Network (VISN) leaders' response to the reported criminal allegations, and review the facility's oversight of the subject physician.[3] The OIG did not identify concerns about patient deaths after conducting an independent review of patient electronic health records, facility data, and the results of a VISN review of patients who were cared for by the subject physician.

The OIG retrieved data from the Veterans Health Administration (VHA) Corporate Data Warehouse and identified 105 patients whose electronic health record (EHR) reflected that the subject physician documented an action such as a progress note, procedure, an order for medication, laboratory work, or a consult.[4] The OIG identified that 17 of the 105 patients died, and reviewed the 17 electronic health records to assess the quality of care provided by the subject physician and to determine if facility clinical staff provided supervision per VHA requirements.

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[1] VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012. The handbook, which was in effect during the time the events discussed in this report occurred, was rescinded, and replaced by VHA Directive 1400.01, *Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents*, November 7, 2019. The handbook and directive contain similar language related to a fellow. A fellow is a post-residency physician, who is pursuing studies in a specialized field of medicine.

[2] The subject physician trained in the Community Living Center, Hospice and Palliative Medicine service, Geriatric Primary Care, Home Based Primary Care, and inpatient psychiatry and neurology units.

[3] For the purposes of this report, the OIG considered facility leaders to include senior level executives, service chiefs, and chief medical officers.

[4] The OIG team focused on inpatient records, including the CLC and geriatric inpatient consults, and excluded VA outpatient clinic entries from the comprehensive EHR review.

The OIG found no deficiencies in quality of care provided by the subject physician and did not identify any indicators suggesting that the patients, who were generally receiving end-of-life care, died from events outside the naturally expected clinical course.[5]

The OIG noted an acceptable level of patient care management for a fellow, and evidence of supervision per VHA and Accreditation Council for Graduate Medical Education (ACGME) requirements.[6] The OIG also reviewed facility mortality data and found no statistically significant relationship between the subject physician's fellowship tenure and assigned rotations, and patient deaths. The OIG found the facility mortality review process met VHA requirements.

The OIG determined that, upon awareness of the subject physician's arrest in early 2021, facility leaders initiated an issue brief and conducted an EHR review of patients that the subject physician treated.[7] The OIG noted that the VISN-led review only included two patient deaths and, based on the nature of the criminal charges against the subject physician, the OIG concluded that a risk-based review should focus on highly vulnerable patients and whether the subject physician provided care not consistent with safe and appropriate practices prior to the patients' deaths. Upon request of the OIG, the VISN completed a review of seven relevant patient deaths and noted "[a] thorough review of [subject physician's] care and attending oversight …was not remarkable for any clinical deficits or medication mismanagements that could have contributed to the veterans' morbidities or mortalities."

The OIG found facility staff and leaders, in conjunction with UNR, onboarded the subject physician per VHA requirements. The OIG also determined that attending physicians supervised and evaluated the subject physician's performance throughout the fellowship, following VHA requirements and standards set by the ACGME. The OIG reviewed the subject physician's performance evaluations and found that they met performance standards, including ACGME milestones for patient care management.

The OIG made no recommendations.

[5] The OIG team reviewed the deaths of patients for whom the subject physician provided care, for *unexpected* outcomes or deaths, as most patients were receiving hospice/palliative care and reasonably expected to die given their clinical conditions.

[6] ACGME, *What We Do*, accessed June 9, 2021, https://www.acgme.org/What-We-Do/Overview/. ACGME sets the standards and accreditation for graduate medical education, such as fellowships, in the United States. VHA Handbook 1400.01, 2012. VHA's use of the term "resident" incorporates fellows, who are residents participating in subspecialty training, such as geriatrics.

[7] Facility leaders identified a conflict of interest within the facility's EHR review process and VISN leaders assumed responsibility for the review. Facility leaders told the OIG that the conflict of interest surrounded the Associate Chief of Staff for Geriatric and Extended Care's close relationship with the subject physician.

Comments

The Veterans Integrated Service Network Director and Acting Facility Director concurred with the report (see appendixes A and B). No further action is required at this time.

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Contents

Abbreviations

ACGME	Accreditation Council for Graduate Medical Education
CLC	community living center
EHR	electronic health record
OIG	Office of Inspector General
TQCVL	Trainee Qualifications and Credentials Verification Letter
UNR	University of Nevada, Reno
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the oversight and performance of a physician in fellowship training (subject physician) at the VA Sierra Nevada Health Care System in Reno (facility).[1]

Background

The facility is part of Veterans Integrated Service Network (VISN) 21, and consists of the Ioannis A. Lougaris VA Medical Center in Reno, Nevada, along with five community-based outpatient clinics and one rural health outreach clinic. The facility is affiliated with the University of Nevada School of Medicine, Reno (UNR), and the University of California East Bay Surgical Program. From October 1, 2018, through September 30, 2019, the facility served over 33,300 patients and operated 64 hospital beds and 60 community living center (CLC) beds.

Veterans Health Administration Fellowships

After completing initial medical education and residency, a physician may participate in a fellowship, including fellowships at UNR.[2] Per the Veterans Health Administration (VHA) Office of Academic Affiliations, VHA fellowships provide physicians a mentored educational and practical experience to develop specific clinical and leadership skills.[3] VHA has educational

[1] VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012. The handbook, which was in effect during the time the events discussed in this report occurred, was rescinded, and replaced by VHA Directive 1400.01, *Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents*, November 7, 2019. The handbook and directive contain similar language related to a fellow. A fellow is a post-residency physician, who is pursuing studies in a specialized field of medicine.

[2] Merriam-Webster, "Definition of Residency," accessed April 19, 2021, https://www.merriam-webster.com/dictionary/residency. Residency refers to a period of continued education, supervision, and training in a medical specialty after medical school graduation and licensure. "Geriatric Medicine Fellowship," University of Nevada, Reno School of Medicine, accessed July 27, 2021, https://med.unr.edu/internal-medicine/geriatrics#:~:text=The%20University%20of%20Nevada%2C%20Reno%20School%20of%20Medicine,of%20internal%20medicine%20or%20family%20medicine%20residency%20programs.

[3] "To Educate for VA and the Nation," VHA Office of Academic Affiliations, accessed July 27, 2021, https://www.va.gov/oaa/. "Medical and Dental Education," VHA Office of Academic Affiliations, accessed July 27, 2021, https://www.va.gov/oaa/medical-and-dental.asp. VHA's Office of Academic Affiliations has oversight of VHA health care profession training and trainees, including graduate medical education.

partnerships, or affiliations, with local medical schools and universities to provide clinical training at VHA facilities.[4]

All VHA fellows are required to "function under the supervision of supervising practitioners" in accordance with the training program. Supervising practitioners are licensed independent providers and are also referred to as "attending" or "faculty."[5] Supervision must follow the Accreditation Council for Graduate Medical Education (ACGME) requirements that state the facility is "responsible for providing residents with direct experience in progressive responsibility for patient management."[6] The graduated supervision process allows the fellow to achieve increased independence over the fellowship tenure.[7] Fellows provide general medical care, including evaluation and management, and may order medications, diagnostic tests, and therapies. However, per VHA, the supervising attending decides the level of supervision the fellow receives. Documentation of supervision in the electronic health record (EHR) must be present, clear, and may occur in the fellow's progress note or in a separate entry by the supervising attending.[8]

Concerns

In early 2021, the Ontario Provincial Police, Canada, arrested the subject physician, a specialist in internal medicine at a hospital in Canada, for the alleged murder of a patient. The Ontario Provincial Police continue to investigate the subject physician's role in other suspicious deaths.[9] The subject physician held an Ontario medical license until the provincial medical board

[4] "About Office of Academic Affiliations," VHA Office of Academic Affiliations, accessed June 14, 2021, https://www.va.gov/OAA/resources_about_oaa.asp. "Medical and Dental Education," VHA Office of Academic Affiliations, accessed June 21, 2021, https://www.va.gov/oaa/medical-and-dental.asp. "Applying to Residencies with ERAS®, "Association of American Medical Colleges," accessed June 21, 2021, https://students-residents.aamc.org/applying-residencies-eras/applying-residencies-eras.

[5] VHA Handbook 1400.01, 2012. For the purpose of this report the OIG refers to a supervising practitioner as a supervising attending. The subject physician's clinical supervisors were attending physicians.

[6] "What We Do," Accreditation Council for Graduate Medical Education, accessed June 9, 2021, https://www.acgme.org/What-We-Do/Overview/. ACGME sets the standards and accreditation for graduate medical education, such as fellowships, in the United States. VHA Handbook 1400.01, 2012. VHA's use of the term "resident" incorporates fellows who are "individuals in approved subspecialty graduate medical education programs" such as geriatrics.

[7] Accreditation Council for Graduate Medical Education, *ACGME Common Program Requirements (Post-Doctoral Education Program),* June 10, 2018 and *ACGME Common Program Requirements (Fellowship),* July 1, 2019. For the purposes of this report, the OIG will reference ACGME fellowship program requirements for the 2018 and 2019 academic years as the subject physician's tenure spanned this time period. Although the titles differ, both documents contain similar language related to the referenced requirements.

[8] VHA Handbook 1400.01, 2012.

[9] The Office of Investigations is one of six directorates within the OIG and "investigates potential crimes and civil violations of law involving VA programs and operations committed by VA employees, contractors, beneficiaries, and other individuals." VA OIG, Semiannual Report to Congress, Issue 84 | April 1–September 30,2020. The OIG Office of Investigations learned that the criminal investigation in Ontario is ongoing and records are sealed and unavailable to the public.

suspended the license, subsequent to the criminal charges.[10] The subject physician participated in a geriatric fellowship at UNR and the facility from early fall 2018 through early fall 2019.

The OIG first learned of the subject physician's arrest through a report from a confidential complainant to the OIG Hotline. While there were no specific allegations related to the subject physician's employment as a fellow at the facility, an OIG inspection was initiated to

- perform an independent review of the quality of care provided by the subject physician to facility patients,
- assess the facility and VISN leaders' response to the reported arrest and nature of criminal allegations, and
- review the facility oversight of the subject physician.[11]

Scope and Methodology

The OIG initiated the inspection on April 6, 2021, and conducted a virtual site visit from May 5 through 17, 2021.

The OIG interviewed VISN and facility senior level executives, Designated Education Officers, the Peer Review Coordinator; facility staff physicians from the Geriatrics and Extended Care service line including the current and former Geriatric Fellowship Program Directors, and the subject physician's supervising attendings at the time of the fellowship. Other interviewees included staff physicians who assisted in the facility review of the subject physician's patient care, and a colleague-fellow of the subject physician.[12]

The OIG reviewed VHA policies and handbooks; facility fellowship processes and workflows; organizational charts; internal VISN and facility reviews and communications regarding the subject physician's patient care during the fellowship tenure; an issue brief; the subject physician's onboarding documents and performance evaluations; communication between the facility and UNR regarding the subject physician; facility mortality and peer review processes; and VISN and facility patient lists and EHR reviews.

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[10] College of Physicians and Surgeons of Ontario, *Doctor Search*, accessed April 20, 2021, https://doctors.cpso.on.ca/. The subject physician also held a medical license in Saskatchewan, Canada, beginning in 2012; however, as of April 6, 2021, the license was not active.

[11] For the purposes of this report, the OIG considered facility leaders to include senior level executives, service chiefs, and chief medical officers.

[12] VISN and facility senior level executives interviewed included the VISN 21 Chief Medical Officer, Deputy Quality Management Officer, and Palliative Care and Hospice Lead; the facility's Acting Director, Acting Chief of Staff, Chief of Informatics, and the Associate Chief of Staff for Geriatrics and Extended Care (Associate Chief of Staff for Geriatrics). Per interviews it was reported that on May 2, 2021, the facility's Chief of Staff began as the Acting Director and the Deputy Chief of Staff became the Acting Chief of Staff. The former Geriatric Fellowship Program Director (Fellowship Director), retired from VHA, but held the directorship during the subject physician's fellowship tenure.

The OIG team used the VHA Corporate Data Warehouse to identify patients for whom the subject physician provided care, during the fellowship period.[13] From this patient list, the OIG identified 17 patients who died between early fall 2018 and mid-fall 2019, and conducted an independent EHR review for quality of care and evidence of fellow supervision.[14]

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1101, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[13] "Corporate Data Warehouse," VA, Health Services Research and Development, accessed July 2, 2021, https://www.hsrd.research.va.gov/for_researchers/vinci/cdw.cfm. The Corporate Data Warehouse is a large-scale data warehouse, collecting near real-time health care data from VHA's EHR system.

[14] The OIG team determined that, given the nature of allegations against the subject physician in Canada, it was relevant to review patient deaths that occurred over one month beyond the subject physician's fellowship tenure but close in time to the documented care.

Inspection Results

Given the criminal allegations levied in Ontario, Canada, the OIG focused this inspection on patient care provided by the subject physician at the facility. The OIG did not identify concerns about patient deaths after conducting an independent review of patient EHRs, facility data, and the results of a VISN review of patients who were cared for by the subject physician. The OIG also determined that attending physicians supervised and evaluated the subject physician's performance throughout the fellowship, as required.

1. OIG's Independent Review

The OIG found no deficiencies in quality of care provided by the subject physician and did not identify any indicators suggesting that the patients, who were generally receiving end-of-life care, died from events outside the naturally expected clinical course.[15] The OIG noted an acceptable level of patient care management for a fellow, and evidence of supervision per VHA and ACGME requirements. The OIG also reviewed facility mortality data and found no statistically significant relationship between the subject physician's fellowship tenure and assigned rotations, and patient deaths. The OIG reviewed and found the facility mortality review process met VHA requirements.

The facility, in collaboration with UNR, offers a Geriatric Medicine Fellowship where physician fellows receive training in geriatrics, hospice and palliative care, inpatient rehabilitation, post-acute and long-term care, inpatient and outpatient care, and home care.[16] Fellows generally rotate on a four-week basis, through multiple locations, including the facility's inpatient units, CLC and outpatient clinics, as well as university and not-for-profit settings.[17]

The subject physician provided care to patients at the facility's CLC, CLC-Hospice and Palliative Medicine service, Geriatric Primary Care, Home Based Primary Care, and the inpatient psychiatry and neurology units. The OIG retrieved data from the VHA Corporate Data Warehouse and identified 105 patients whose EHR reflected that the subject physician documented an action such as a progress note, procedure, an order for medication, laboratory

[15] The OIG team reviewed the deaths of patients, for whom the subject physician provided care, for *unexpected* outcomes or deaths as most patients were receiving hospice/palliative care and reasonably expected to die given their clinical conditions.

[16] VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics*, October 11, 2016. "Hospice and palliative care is a continuum of comfort-oriented and supportive services provided in home, community, outpatient, or inpatient settings for Veterans with advanced life-limiting disease. HPC's [Hospice and palliative care] goal is to achieve the best possible quality of life through relief of suffering, control of symptoms, and restoration of functional capacity to the greatest extent possible."

[17] University of Nevada Reno, School of Medicine, *Department of Internal Medicine – Clinical Experiences*, accessed April 19, 2021, https://med.unr.edu/internal-medicine/geriatrics/clinical. The subject physician also practiced at local non-VA facilities as part of the fellowship program. VA providers did not have oversight and did not supervise the subject physician during episodes of care at non-VA facilities.

work, or a consult.[18] The OIG further identified that 17 of the 105 patients died between early fall 2018 and mid-fall 2019.

EHR Review

The OIG conducted an independent review of EHRs of the 17 deceased patients to assess the quality of care provided by the subject physician and to determine if facility clinical staff provided supervision per VHA requirements. Six patient EHRs indicated only minimal entries by the subject physician, such as an order for a consult, a routine medication, or a laboratory test, and the OIG determined that further review was not warranted. The OIG team conducted a comprehensive review of the remaining 11 patients for whom the subject physician provided a more significant level of care. Of the 11 patient records reviewed, the OIG found

- no deficiencies in care provided, nor any nefarious actions on the part of the subject physician;[19]
- three of the CLC resident deaths occurred in the hospice unit and were expected deaths;[20]
- the subject physician was present for only one CLC resident death;[21]
- one patient died in the facility's intensive care unit; and[22]
- seven of the patient deaths occurred outside of the facility (at home or at a non-VA hospice environment), and all seven patients died more than one week after the last known encounter with, or EHR entry by, the subject physician.

Through EHR reviews, the OIG found that for progress notes written by the subject physician, appropriate supervision was indicated as evidenced by an attending physician's co-signature, presence of the attending physician at the encounter, or the attending physician's documented review of care and concurrence.

[18] The OIG team focused on inpatient records, including the CLC and geriatric inpatient consults, and excluded outpatient entries from the comprehensive EHR review.

[19] The OIG team reviewed EHRs, including medication orders, types, and dosage.

[20] "What is Hospice?" Hospice Foundation of America, accessed June 29, 2021, https://hospicefoundation.org/Hospice-Care/Hospice-Services. Patients in hospice care generally have less than six months to live and are "rapidly declining despite medical treatment." Patients may want to "live more comfortably and forego treatments aimed at prolonging life."

[21] In this instance, a nurse found the patient in distress and called for assistance from the subject physician. The patient died before interventions could be initiated.

[22] For this patient, the subject physician's role was consultative to establish life sustaining treatment decisions on the day prior to the patient's death.

Mortality Data

The OIG retrieved and analyzed data from the VHA Corporate Data Warehouse regarding facility mortality data. The OIG found no statistically significant increase in CLC and Acute Care mortality during the subject physician's rotations at the facility.

In reviewing the mortality data, the OIG noted an increase in CLC deaths during the months of July and August 2019. While not a statistically significant increase in deaths, to ensure a thorough review the OIG performed a review of the EHRs of 20 patients who died during July and August for any indicators of deaths occurring outside the naturally expected course. The OIG found all 20 deaths were anticipated and closely monitored.[23]

OIG Review of Facility Internal Quality Reviews

The OIG learned that the facility had an established process to review patient deaths, including mortality and peer reviews, and found that the review processes met VHA requirements. Further, the OIG determined that during the time frame of interest, the mortality review process for the CLC and hospice did not trigger a peer review relevant to this inspection.

As part of a comprehensive quality management program, VHA requires facilities to evaluate the provision of care and identify opportunities for improvement.[24] Occurrence screening is "the screening of cases against a list of criteria…to identify possible problems in patient care." Occurrence screens are generated through the EHR system and identify certain events, such as death during inpatient hospitalization, requiring further review.[25]

Per VHA, facility leaders may be required to, or elect to do a focused review such as a peer review for quality management, to address a specific episode of care.[26] Through the peer review process, clinical peers evaluate "care provided by individual clinicians within a selected episode of care," and identify areas for improvement in clinical practice or healthcare systems.[27]

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[23] The subject physician did not provide care to 18 of the 20 patients and was minimally involved in the care of two patients by writing orders for laboratory work and a non-narcotic medication.

[24] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. VASNHCS 00-11-1D*, Peer Review for Quality Management*, July 2010. This policy was in effect at the time of certain events discussed in this report until it was rescinded February 19, 2019, by Facility Notice 2019-00X-1, *Recission of VASNHCS Directive 00-11-1D, Peer Review for Quality Management*, February 19, 2019, which noted that on November 21, 2018, VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018, removed the requirement for facility-based policy. The policies contain the same or similar language related to peer review and quality management.

[25] VHA Directive 2008-077, *Quality Management (QM) and Patient Safety Activities That Can Generate Confidential Documents*, November 11, 2008, rescinded by VHA Directive 1320, *Quality Management and Patient Safety Activities That Can Generate Confidential Records and Documents*, July 10, 2020. VHA Directive 2008-077 was in effect during the subject physician's tenure at the facility. VHA Directive 1190.

[26] VHA Directive 2008-077.

[27] VHA Directive 1190.

VHA requires that expected deaths, such as those involving patients in hospice or palliative care, be reviewed.[28] VHA defines these as mortality reviews that involve "discussions among clinicians of the care provided to individual patients who died or experienced complications," including "preliminary reviews of care."[29] VHA and facility policy require a peer review when a mortality review identifies certain clinical events that preceded a patient's death.[30] These mandatory peer review triggers include an adverse event, "lack of appropriate palliative care," treatment complication, or changes in a patient's conditions with a questionable facility staff response.[31] Facility requirements explicitly note that the "diagnosis of a 'terminal' illness, the existence of an advance directive, or a do not resuscitate status are not considered exceptions" to the mortality and peer review processes.[32]

Per VHA, fellows are not subject to peer review while in a trainee role and must be under the supervision of a licensed provider.[33] In such a case, VHA requires the peer review to focus on the attending physician and make a determination as to whether the supervision was appropriate.[34]

The Acting Chief of Staff told the OIG that the Peer Review Coordinator screened all inpatient and CLC deaths and that "deaths that are unexpected or have opportunities for improvement are sent for peer review." Additionally, "[a]ll acute inpatient hospice deaths are sent to [Associate Chief of Staff] Geriatrics for review to see if hospice care and process was done appropriately, and if not these are sent for peer review. All non-hospice inpatient deaths are peer reviewed."

The facility's Peer Review Coordinator (a registered nurse) told the OIG that occurrence screens that identify patient deaths in the facility, including inpatient and CLC, are reviewed and trigger the initiation of the peer review process if the event is concerning. Additionally, the Peer Review

[28] VHA Directive 1190.

[29] VHA Directive 2008-077.

[30] VHA Directive 1190. VASNHCS 00-11-1D.

[31] VHA Directive 1190. Adverse events are "untoward incidents, therapeutic misadventures, … or other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical facility, outpatient clinic, or other VHA facility." VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

[32] VASNHCS 00-11-1D.

[33] VHA Handbook 1400.01, 2012. A fellow "may be credentialed and privileged for independent practice only in the discipline in which they have attained board certification or have completed the training for board eligibility." The fellow would be subject to peer review only for the licensed and independent work performed outside of the fellowship. For example, a board-certified internal medicine provider may also participate in a separate geriatric fellowship; a peer review would only apply where the individual was also working as an internal medicine provider, outside of the training environment.

[34] VHA Directive 1190.

Coordinator reported working closely with the Associate Chief of Staff for Geriatrics and the Chief of Quality Management to report any concerns regarding deaths.[35]

The facility's Office of the Deputy Director further advised that no peer reviews were triggered for the relevant providers during the subject physician's fellowship tenure. The OIG found that the facility mortality and peer review processes met VHA and facility requirements, and that no concerns were raised regarding the subject physician's performance.

2. Facility and VISN Leaders' Response

The OIG found that, upon awareness of the subject physician's arrest in early 2021, facility leaders initiated an issue brief and oversaw the initiation of an EHR review of patients that the subject physician treated. The OIG found that the issue brief met VHA guidelines. Facility leaders identified a conflict of interest within the EHR review process and VISN leaders assumed responsibility for the review. The OIG determined that the initial VISN-led EHR review did not capture a risk-based representation of the subject physician's patients, and upon request of the OIG, the VISN completed a more thorough review of patient deaths.

Issue Brief

Per VHA, issue briefs provide VHA leaders with specific information about a situation or event that may affect care or "generate media interest." Issue briefs should be updated "as new information develops," and should include actions taken. Updates to an issue brief continue until the issue is resolved. Additionally, issue briefs should be completed within one business day when a criminal allegation against an employee or issues that draw media attention occur.[36] The OIG found that facility leaders met VHA guidelines as they became aware of the subject physician's arrest and criminal charges early 2021, and initiated the issue brief to VISN and VHA leaders the next day. The OIG also reviewed facility leaders' updates to the issue brief. The OIG found that facility leaders provided updates when additional information became available.

EHR Reviews

Per VHA, a look-back, or EHR review is "an organized process for identifying patients or staff with exposure to potential risk incurred through past clinical activities, with the explicit intent to notify them and offer care and recourse, as appropriate."[37] The Joint Commission provides guidance on sampling for quality measures but cautions against sampling without a large number of cases to achieve a representative sample of the population. The Joint Commission also notes

[35] The peer review coordinator was in this role during the subject physician's fellowship tenure.

[36] Deputy Secretary for Health for Operations and Management (10N), *10N Guide to VHA Issue Briefs*, March 29, 2018.

[37] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

that although sampling is not required, a facility may consider the benefit achieved through a review of all relevant cases.[38]

Facility Review of the Subject Physician's Patients

Facility leaders told the OIG that once aware of the subject physician's arrest, they initiated an EHR review of the subject physician's former patients.[39] The Acting Chief of Staff told the OIG that the Associate Chief of Staff for Geriatrics was assigned to facilitate the EHR review.

The Associate Chief of Staff for Geriatrics began assignment of the EHR review to two facility physicians, a geriatrician and a hospice and palliative care provider.[40] However, the OIG learned that facility leaders identified a conflict of interest and shifted the review to the VISN level.[41]

VISN Reviews of the Subject Physician's Patients

On April 12, 2021, the Acting Chief of Staff emailed the list of more than 90 patients to the VISN Chief Medical Officer.[42] The VISN Chief Medical Officer emailed VISN leaders and on April 16, 2021, the VISN assigned a subject matter expert to initiate the EHR review. Per the VISN Chief Medical Officer, a meeting was then held with VISN leaders and the subject matter expert reviewer to: discuss the plan; confirm the subject matter expert was willing to perform the reviews; identify the percentage of EHRs to be reviewed; and assign the VISN Deputy Quality Management Officer to conduct a random sample of EHRs for review.

First VISN EHR Review

The VISN Chief Medical Officer told the OIG that, upon the advice of the VISN Deputy Quality Management Officer, they decided to use a 10 percent random sample of the facility's patient list for their EHR review. The VISN Deputy Quality Management Officer provided the subject

[38] "About the Joint Commission," The Joint Commission, accessed June 24, 2021, https://www.jointcommission.org/about-us/. The Joint Commission is a healthcare accreditation organization whose focus is "safe and effective care of the highest quality and value." The Joint Commission, *Specifications Manual for Joint Commission National Quality Measures*, *Population and Sampling Specifications,* accessed May 20, 2021, https://manual.jointcommission.org/releases/TJC2021A1/SamplingChapterTJC.html.

[39] The Acting Chief of Staff asked a facility employee to compile a patient list that captured all the subject physician's signed progress notes. Through interviews, the OIG learned that once compiled, the employee sent the list of patients to the Acting Chief of Staff.

[40] The OIG team interviewed facility leaders and clinicians, in addition to reviewing internal emails.

[41] Facility leaders told the OIG that the conflict of interest surrounded the Associate Chief of Staff for Geriatric's close relationship with the subject physician.

[42] The VISN Deputy Quality Management Officer noted 97 patients on the facility generated list; the OIG team reviewed the final facility list and identified 91 unique patients.

matter expert with nine patient names to review.[43] The subject matter expert completed the EHR review a week later.

The OIG interviewed the subject matter expert and reviewed the findings. The subject matter expert told the OIG that VISN leaders asked that the review focus on the subject physician's clinical judgment, any patient care complications, issues with medications, and confirmation of attending oversight. The subject matter expert also informed the OIG that "I did not pinpoint anything that was egregious" during the EHR review. Although the OIG did not independently verify the review, the OIG found that the review exhibited a close examination of the nine patient EHRs.

However, the OIG found that the VISN-led review of the nine patients, included two patient deaths, and did not reflect the concerns related to the criminal allegations against the subject physician. Additionally, the OIG concluded that the number of patient deaths reviewed did not adhere to The Joint Commission's guidance regarding the benefit of the patient population reviewed. The OIG concluded that based on the nature of the criminal charges against the subject physician, a risk-based EHR review should focus on highly vulnerable patients and whether the subject physician provided care not consistent with safe and appropriate practices prior to the patients' deaths.

On May 27, 2021, in an exit briefing with facility leaders, the OIG expressed concern that the VISN-led EHR review did not include all deaths of patients under the direct care of the subject physician. The OIG further stated in the briefing, that "given the allegations surrounding the subject physician's arrest in Canada, the OIG is concerned that a more focused VISN review is warranted, specifically deaths of patients that the subject physician cared for between [early fall 2018 and mid-fall 2019.]" The VISN Chief Medical Officer acknowledged the concern and agreed to facilitate a review capturing the subject physician's patients who had died during that time frame.

Second VISN EHR Review

On June 25, 2021, the VISN 21 Chief Medical Officer provided the results of a review of the EHRs of seven patients who received care from the subject physician, and who had died. The subject matter expert noted "[a] thorough review of [subject physician's] care and attending oversight…was not remarkable for any clinical deficits or medication mismanagements that could have contributed to the veterans' morbidities or mortalities."[44] Although the OIG did not

[43] Through interviews the OIG learned the VISN assigned subject matter expert is the VISN 21 lead for hospice and palliative care and is board certified in hospice and palliative medicine. VISN leaders told the OIG about the EHR review assignment to the subject matter expert.

[44] The VISN-assigned subject matter expert performed both VISN reviews.

independently verify the review, the OIG found that the review exhibited a close examination of the seven patient EHRs.

The OIG concluded that facility leaders responded appropriately by completing an issue brief detailing their awareness and response, which documented the initiation of an EHR review of the subject physician's patients. The OIG also concluded that although the first VISN-led review did not capture a clinically relevant patient population, per The Joint Commission's guidance, VISN leaders ultimately ensured a comprehensive review was performed.[45]

3. Oversight of the Subject Physician

The OIG found facility staff and leaders, in conjunction with UNR, onboarded the subject physician per VHA requirements. The OIG also determined that attending physicians supervised and evaluated the subject physician's performance throughout the fellowship, following ACGME standards and VHA requirements, and identified no performance or care concerns.

Subject Physician's Onboarding at the Facility

VHA requires an affiliation agreement between facilities and sponsoring educational institutions.[46] The affiliation agreement between the facility and UNR states the responsibility for the selection and appointment of qualified and credentialed fellows is shared between both entities.[47] Although VHA does not require facilities to credential fellows functioning as trainees, VHA's Office of Academic Affiliations requires a Trainee Qualifications and Credentials Verification Letter (TQCVL).[48] The TQCVL verifies the fellow's qualifications to participate in the training program such as medical education and licensure, as well as certification as a foreign medical graduate for international trainees. "A TQCVL from the director of the sponsoring (VA or non-VA) program must be submitted to the VA Facility Director through the VA Designated Education Officer (DEO) prior to onboarding."[49] A fellow's onboarding process is finalized

[45] The VISN reviewed 16 patients in total for the combined reviews, including nine patient deaths. The OIG reviewed 11 patient deaths, including two not reviewed by the VISN. The OIG found these two patients received minimal care from the subject physician and the OIG did not request further review by the VISN.

[46] VHA Handbook 1400.05, *Disbursement Agreement Procedures for Physician and Dentist Residents*, August 14, 2015.

[47] VHA Directive 2012-03, *Credentialing of Health Care Professionals*, October 11, 2012. An applicant's position required that education, experience, and licensure is verified through the credentialing process. "Medical Education Affiliation Agreement Between Department of Veteran Affairs (VA), and Institutions Sponsoring Graduate Medical Education and Their Affiliated School of Medicine," VA Sierra Nevada Health Care System, Reno, and University of Nevada, Reno, School of Medicine, July 7, 2017.

[48] VHA Handbook 1400.01, 2012.

[49] VHA Handbook 1400.05. The facility Designated Education Officer is responsible for all coordination, oversight, and accountability of the program. VHA Office of Academic Affiliations, *VHA Office of Academic Affiliations (10A2D): Guide to Completing the Trainee Qualifications and Credentials Verification Letter (For Both Affiliate and VA Program Directors),* March 2018. The VHA's Office of Academic Affiliations requires all non-US citizen trainees have approval from the facility director or designee.

when the facility director signs the TQCVL and additional administrative VHA onboarding documents are completed.[50]

The Fellowship Director, who was both UNR faculty and a facility staff geriatrician, explained "a pretty thorough vetting process" of fellows.[51] The process for the subject physician included an interview and review of proof of clinical residency, as well as letters of recommendation.[52] The OIG reviewed the subject physician's onboarding documents and determined UNR verified the subject physician's education, licensure, and immigration status to train within the United States as VHA requires.

The OIG found that the Fellowship Director, the facility's Designated Education Officer, and the Facility Director signed the subject physician's TQCVL.[53] The Nevada State Board of Medical Examiners granted the subject physician a license to practice in the fall of 2018, and the subject physician began the fellowship on the same date.[54]

The OIG concluded the subject physician's onboarding process met VHA requirements.

Supervision and Ongoing Evaluation

During fellowship, supervising attendings evaluate a fellow's performance through the practice of progressive responsibility.[55] VHA and the affiliation agreement between the facility and UNR state evaluation of a fellow's performance must follow the training program's accreditation standards.[56] ACGME standards for supervising attendings to evaluate a fellow's performance include

[50] Facility Checklist, "Trainee Onboarding Checklist and Flowchart – Attachment A," updated October 28, 2016. VHA administrative onboarding documents include federal applications for health professions trainees, a background check, and completion of mandatory training.

[51] In an interview with the OIG, the Fellowship Director confirmed the role held was a dual appointment—as the UNR fellowship program director and as a facility staff geriatrician and VA site fellowship director through VHA.

[52] The Fellowship Director explained to the OIG their review of a prior disciplinary action against the subject physician and their satisfaction that those issues were properly addressed and resolved. The Nevada Board of Medical Examiners also reviewed those allegations prior to granting a medical license in Nevada. The OIG determined further analysis was out of the scope of this inspection.

[53] The OIG reviewed VHA administrative onboarding documents, including the subject physician's background check and training, and identified no concerns. The OIG determined further review of the onboarding process was outside the scope of this inspection.

[54] Through document reviews the OIG found the delays in licensure were due to the visa status of the subject physician.

[55] VHA Handbook 1400.01, 2012.

[56] VHA Handbook 1400.01, 2012. *Medical Education Affiliation Agreement Between Department of Veteran Affairs (VA)*, July 7, 2017.

- documentation of evaluations upon completion of clinical rotations,
- completion of a final evaluation, which the educational institution retains as permanent record, and
- frequent feedback based upon direct observations and evaluation.[57]

The OIG interviewed a number of the subject physician's supervising attendings, who described a fellow's supervision as graduated and one supervising attending further described a fellow's supervision as intense. The Associate Chief of Staff of Geriatrics further told the OIG that supervision of a fellow in the CLC is "hands on," which includes discussions of each patient and working closely with the interdisciplinary team.

The facility's Designated Education Officer told the OIG that performance evaluations of fellows are expected after each clinical rotation and at the fellowship's conclusion. The OIG also learned, from the Fellowship Director, that documentation of evaluations is captured through ACGME Milestones.[58] A number of the subject physician's supervising attendings told the OIG of providing ongoing feedback to the subject physician based upon their observations.

The OIG reviewed the subject physician's performance evaluations and found that they met performance standards, including ACGME milestones, for patient care management. The OIG concluded the subject physician received proper supervision and evaluation during the fellowship tenure per VHA requirements and ACGME standards.

Conclusion

The OIG identified no deficiencies in quality of care provided by the subject physician and did not identify any indicators to suggest that patient deaths occurred outside the naturally expected clinical course. The OIG noted an acceptable level of patient care management for a fellow, and evidence of supervision per VHA and ACGME requirements. The OIG also reviewed facility mortality data and found no statistically significant relationship between the subject physician's fellowship tenure and assigned rotations, and patient deaths. The OIG reviewed and found the facility mortality review process met VHA requirements.

The OIG conducted an independent EHR review of 17 deceased patients to assess the quality of care provided by the subject physician and to determine if facility clinical staff provided supervision per VHA requirements. The OIG found no deficiencies in care provided.

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[57] ACGME, *Common Program Requirements (Post-Doctoral Education Program)*, June 10, 2018, and ACGME, *Common Program Requirements (Fellowship)*, July 1, 2019.

[58] Milestones are medical specialty-specific competencies that allow evaluation based upon direct observations and tracking of a fellow's progress throughout the training program. ACGME*, Common Program Requirements (Post-Doctoral Education Program),* June 10, 2018, and ACGME, *Common Program Requirements (Fellowship),* July 1, 2019.

Through EHR reviews, the OIG found that for progress notes written by the subject physician, appropriate supervision was indicated as evidenced by an attending physician's co-signature, presence of the attending physician at the encounter, or the attending physician's documented review of care and concurrence.

The OIG retrieved and analyzed data from the VHA Corporate Data Warehouse regarding facility mortality data. The OIG found no statistically significant increase in CLC and Acute Care mortality during the subject physician's VA rotations while in the facility geriatric fellowship program.

The OIG also learned that the facility had an established process to review patient deaths, including mortality and peer reviews, and found that the review processes met VHA requirements. Further, the OIG determined that during the time frame of interest, the mortality review process for the CLC and hospice did not trigger a peer review relevant to this inspection.

The OIG found that, upon awareness of the subject physician's arrest in March 2021, facility leaders initiated an issue brief. The OIG determined that the issue brief met VHA guidelines.

Facility leaders oversaw the initiation of an EHR review of patients that the subject physician treated. Facility leaders identified a conflict of interest within the review process and VISN leaders then assumed responsibility; however, the initial VISN-led EHR review did not capture a risk-based representation of the subject physician's patients. Upon request of the OIG, the VISN completed a more thorough review of patient deaths. The VISN reviewer found no "clinical deficits or medication mismanagements that could have contributed to the veterans' morbidities or mortalities."

The OIG found facility staff and leaders, in conjunction with UNR, onboarded the subject physician per VHA requirements. The OIG also determined that attending physicians supervised and evaluated the subject physician's performance throughout the fellowship, following ACGME standards and VHA requirements, and identified no care concerns.

The OIG made no recommendations.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 7, 2021

From: Director, VA Sierra Pacific Network (10N21)

Subj: Healthcare Inspection—Facility Leaders Provided Oversight of a Physician in Training at VA Sierra Nevada Health Care System in Reno

To: Director, Office of Healthcare Inspections (54HL07)
Director, GAO/OIG Accountability Liaison office (VHA 10BGOAL Action)

1. Thank you for the opportunity to review the draft report, *Healthcare Inspection – Facility Leadership Provided Oversight of a Physician in Training at VA Sierra Nevada Health Care System in Reno.* I concur with the report and no findings.
2. If you have any questions, please contact the VISN21 Accreditation Program Manager.

(*Original signed by*:)

John A. Brandecker, MPA, MPH
VISN 21 Network Director

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 1, 2021

From: Acting Director, VA Sierra Nevada Health Care System (654)

Subj: Healthcare Inspection—Facility Leaders Provided Oversight of a Physician in Training at VA Sierra Nevada Health Care System in Reno

To: Director, VA Sierra Pacific Network (10N21)

1. Thank you for the opportunity to review the draft report. I concur with the findings of no deficiencies in quality of care provided by the subject physician.
2. There are no recommendations and no associated action plan.

(Original signed by:)

Amy Sanguinetti, MD, PhD
Acting Director

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