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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Physician's Falsification of VA Video Connect Blood Pressures at the North Las Vegas VA Medical Center in Nevada

HEALTHCARE INSPECTION | REPORT #22-00707-44 | JANUARY 25, 2023

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess concerns regarding a primary care provider (provider) potentially falsifying blood pressure readings (blood pressures) at the North Las Vegas VA Medical Center (facility) in Nevada. Prior to this inspection, the OIG completed a review of administrative data and found that the provider documented 330 blood pressure entries in patient electronic health records (EHRs) for visits that occurred from November 1, 2020, through October 31, 2021. Of these entries, the provider documented 270 (82 percent) blood pressures of 120/80, the accuracy of which was highly unlikely as these measurements were expected to vary across multiple patients. From the 270 entries, the OIG reviewed a sample of 20 EHRs from VA Video Connect (VVC) visits.[1] Due to the frequency of identical blood pressures, the OIG initiated an inspection to assess whether the blood pressures recorded during VVC visits were false, and, if so, to determine the subsequent impact to patients, and evaluate actions taken by facility leaders.

During the inspection, the OIG reviewed vital signs data from the Veterans Health Administration's (VHA) Corporate Data Warehouse and found that the provider entered blood pressures of 120/80 for 312 patients between January 1, 2020, and January 12, 2022.[2] The OIG determined that the provider knowingly documented false blood pressures in patients' EHRs during primary care VVC visits. The provider attributed the falsifications to the belief that the facility VVC template required providers to document a false blood pressure when an actual blood pressure had not been obtained during the visit, and to not having received VVC training. The OIG observed the use of the template by clinical informatics program analysts and confirmed that use of the template was not mandatory, and that providers were able to bypass entering blood pressures in the template.

Contrary to the provider's claim of not receiving VVC training, the OIG reviewed facility documents and determined that the provider completed all required VVC trainings by April 1, 2020. Although the OIG was unable to verify if the required trainings included information on blood pressures, the OIG found that facility leaders emailed the provider instructions for documentation of blood pressures during VVC visits. During an interview with the OIG on January 12, 2022, the provider reported being uncomfortable with the practice of documenting false blood pressures, yet failed to seek assistance.

[1] VVC is an electronic application developed by VA as a platform to deliver clinical services directly to a patient using a patient's mobile device or home computer.

[2] "Corporate Data Warehouse" (web page), Health Services Research and Development, accessed on June 13, 2022, https://www.hsrd.research.va.gov/for_researchers/vinci/cdw.cfm. The Corporate Data Warehouse is a large-scale data warehouse—a collection of healthcare data obtained from VHA's EHR system.

During interviews, the provider reported the belief that, even though blood pressures were falsified, patients were not harmed due to the use of mitigation strategies that included ensuring patients were scheduled with a clinical pharmacist for management of hypertension, sending "everyone" a blood pressure monitor, and writing in progress notes that 120/80 documented in the vital signs package was inaccurate.[3] The OIG reviewed 67 EHRs of the 312 patients and determined that the provider's mitigation efforts had not occurred with most patients reviewed.[4] Of the 67 patients, only 24 were being followed by or had a consult ordered for clinical pharmacy; 9 already had a blood pressure monitor or had one ordered by the provider; and no patient EHRs had documentation noting that the 120/80 blood pressure was inaccurate.

Obtaining and recording accurate blood pressures in the EHR is fundamental for hypertension management. The OIG assessed the 67 EHRs for adverse clinical outcomes and determined that none of the patients reviewed experienced adverse clinical outcomes as a result of the false blood pressures.[5] Of the 67 EHRs, 33 patients had either established cardiovascular disease or hypertension, both of which are high-risk conditions that may require blood pressure monitoring. The OIG found that 26 of these 33 EHRs included documentation of hypertension management during VVC visits such as modifications to medication orders and referrals and consults for cardiovascular management. Additionally, the OIG found the provider's documented blood pressures of 120/80 appeared in three other provider's notes in follow-up visits; however, the OIG did not find documentation that the blood pressures were used to make healthcare decisions.

During the course of the inspection, the OIG alerted facility leaders of the provider's falsification of blood pressures. Facility leaders then facilitated the following actions:

- On January 13, 2022, the Chief of Staff directed the provider to stop entering false blood pressures and notified Human Resources of the potential need for disciplinary action.
- On January 27, 2022, the telehealth coordinator retrained the provider on VVC documentation.
- On March 14, 2022, the direct supervisor initiated a focused professional practice evaluation for cause.[6]

[3] The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[4] Of the 67 EHRs reviewed, 17 were selected based on an emergency department visit that followed the false blood pressure entry, while the remaining 50 were randomly selected for review.

[5] Within the context of this report, the OIG considered adverse clinical outcomes to be defined as death, hospitalization, or significant change in the status of a patient's disease, that in the OIG's assessment, may have been preventable if the blood pressure was not falsified during the VVC visit.

[6] VHA Directive 1190, *Peer Review for Quality Management,* November 21, 2018. A focused professional practice evaluation for cause is designed to allow providers an opportunity to improve an identified clinical concern.

- On March 18, 2022, a staff nurse completed an EHR review of the provider's VVC visits.
- On June 10, 2022, the Chief of Staff notified the OIG that the provider successfully completed the focused professional practice evaluation for cause demonstrating correct documentation practices for entering vital signs.

The OIG determined that although retraining was conducted, the provider continued to display difficulty demonstrating the use of technology and locating the VVC template. During an interview with the OIG, the provider took multiple attempts to locate the template and had difficulty utilizing the camera. Therefore, the OIG remained concerned about the provider's competence to complete primary care VVC visits. The OIG determined that facility leaders failed to initiate reporting the provider to the state licensing board. Although the provider admitted to entering false blood pressures, the Chief of Staff explained that the initiation of a report to the state licensing board did not occur because the provider successfully completed a focused professional practice evaluation for cause. However, VHA policy requires initiation of the state licensing board reporting process when providers "failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients or the community."[7] The state licensing board reporting process is not dependent on other administrative reviews.

Facility leaders attested that EHR entries that included a documented blood pressure of 120/80 from all of the provider's VVC visits were clinically reviewed and amended to reflect that blood pressures were falsified. On May 13, 2022, the OIG evaluated a sample of 100 patients identified in the facility's EHR review and found that not all entries with a blood pressure of 120/80 were clinically reviewed and amended. The Acting Chief of Staff was unable to provide rationale as to why all EHRs were not clinically reviewed or amended when asked by the OIG.

The OIG made five recommendations to the Facility Director related to ensuring the provider's ability to complete and document VVC visits, considering taking administrative action against the provider, considering the need to initiate state licensing board reporting, and ensuring the blood pressure readings the provider entered in patients' EHRs are reviewed and amended.

[7] VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.

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Contents

Abbreviations

EHR	electronic health record
OIG	Office of Inspector General
TMS	Talent Management System
VVC	VA Video Connect
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the North Las Vegas VA Medical Center (facility) in Nevada to assess concerns related to a provider potentially falsifying blood pressure readings (blood pressures) in patients' electronic health records (EHRs).

Background

The facility, part of the VA Southern Nevada Healthcare System and Veterans Integrated Service Network (VISN) 21, is a medical center with 130 operating hospital beds providing medical, surgical, mental health, rehabilitation, and domiciliary services in North Las Vegas. The VA Southern Nevada Healthcare System has seven outpatient clinics (located in Southwest, Southeast, Northwest, and Northeast Las Vegas, Nevada; and in West Cheyenne, Pahrump, and Laughlin, Nevada). From October 1, 2020, through September 30, 2021, the healthcare system served 70,342 unique patients, as a level 1b, high complexity facility.[1]

Blood Pressure and Hypertension

Blood pressure is a measurement of the systolic (active) and diastolic (resting) pressure inside a person's arteries with each heartbeat. Normal blood pressure is defined as the systolic less than 120 and diastolic less than 80.[2]

Hypertension is a disease process that affects close to half of adults in the United States and is usually asymptomatic.[3] The American College of Cardiology/American Heart Association notes that hypertension occurs when a patient's blood pressure measurement is a systolic blood pressure ≥130, a diastolic blood pressure ≥80, or both for two or more readings during two or

[1] VHA Office of Productivity, Efficiency and Staffing, "Facility Complexity Model Fact Sheet," January 28, 2021. The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, and educational and research missions. Complexity Levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex; Level 3 facilities are considered the least complex.

[2] "Facts About Hypertension" (web page), Centers for Disease Control and Prevention, accessed March 22, 2022, https://www.cdc.gov/bloodpressure/facts.htm.

[3] "Facts About Hypertension," Centers for Disease Control and Prevention; "What is High Blood Pressure" (fact sheet), American Heart Association, accessed March 28, 2022, https://www.heart.org/-/media/Files/Health-Topics/Answers-by-Heart/What-Is-High-Blood-Pressure.pdf.

more occasions.[4] For patients under treatment for hypertension, normal blood pressures indicate control of, and generally signify that, hypertensive management efforts are effective.

VA Video Connect During COVID-19 Pandemic

VA Video Connect (VVC) is an electronic application developed by VA as a platform to deliver clinical services directly to a patient using a patient's mobile device or home computer.[5]

On March 11, 2020, the Deputy Under Secretary for Health for Operations and Management issued a memorandum on leveraging video telehealth as part of VA's strategy to protect veterans and VA staff from COVID-19. The guidance highlighted priorities for establishing VVC telehealth capabilities for providers and encouraged facilities to consider converting face-to-face visits to virtual visits to reduce COVID-19 exposure risks for patients and staff.[6] Specifically, Veterans Health Administration (VHA) facilities were encouraged to convert as many in-person scheduled medical appointments to VVC visits as clinically appropriate.[7] In February 2020, the VA Southern Nevada Healthcare System, which includes the facility, completed 65 total primary care VVC visits. In April 2020, 890 primary care VVC visits were completed. In September of 2020, the system completed 3,152 primary care VVC visits.

Prior OIG Reports

In September 2018, the OIG published a report, *Falsification of Blood Pressure Readings at the Berea Community Based Outpatient Clinic, Lexington, Kentucky*. The OIG found that a primary care provider falsely documented patients' blood pressures. The OIG reviewed EHRs of patients that had uncontrolled hypertension and multiple co-morbid conditions. The OIG found that a patient experienced an adverse clinical outcome and the provider's inaction to manage hypertension exposed patients to further risks. The OIG made seven recommendations that have been closed.[8]

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[4] Paul K. Whelton, et al., "2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines," *Hypertension* 71, no. 6 (June 2018):e13–e115, https://www.ahajournals.org/doi/epub/10.1161/HYP.0000000000000065.

[5] VA Telehealth, *VA Video Connect Access Your VA Care Team Through Video Telehealth*, July 2021.

[6] VHA Deputy Under Secretary for Health for Operations and Management (10N), "COVID-19: Protecting Veterans and the Department of Veterans Affairs (VA) Workforce by Leveraging Video Telehealth from VA Clinics and Home," memorandum to Veterans Integrated Service Network (VISN) Directors, March 11, 2020.

[7] VHA Deputy Under Secretary for Health for Operations and Management, "COVID-19: Protecting Veterans and the Department of Veterans Affairs (VA) Workforce by Leveraging Video Telehealth from VA Clinics and Home," memorandum.

[8] VA OIG, *Falsification of BP Readings at the Berea Community Based Outpatient Clinic, Lexington, Kentucky*, Report 18-01963-284, September 20, 2018.

In January 2019, the OIG published a report, *Falsification of Blood Pressure Readings at the Danville CBOC, Salem, Virginia.* The OIG identified that a primary care provider falsely documented patients' blood pressures. Although the OIG did not identify patients who experienced adverse clinical outcomes, the OIG found that the false blood pressure entries were not detected or fully reviewed by facility leaders and that the provider had intentionally entered the false blood pressures. The OIG made five recommendations that have been closed.[9]

Concerns

The OIG completed a review of administrative data and found that a primary care provider (provider) documented 330 blood pressure entries on patients during visits from November 1, 2020, through October 31, 2021. Of these entries, 270 (82 percent) contained the same blood pressures of 120/80, which was highly unlikely as these measurements were expected to vary across multiple patients. The OIG reviewed a sample of 20 EHRs from VVC visits and generated a list based on indicator variables for blood pressures of 120/80 and a diagnosis that included a cardiovascular disease such as hypertension, diabetes mellitus, or coronary artery disease. Due to the frequency of the identical blood pressures during VVC visits, the OIG initiated a healthcare inspection. The inspection sought to determine if the blood pressures were false and, if so, to identify what led to the false documentation and whether adverse clinical outcomes occurred.

During the inspection, the OIG identified related concerns regarding the facility leaders' response after learning of the provider's falsification of blood pressures.

Scope and Methodology

The OIG initiated the inspection on November 29, 2021, and conducted a virtual site visit January 10–20, 2022. Additional interviews were conducted through March 2, 2022.

The OIG interviewed the VISN 21 connected care program manager; the VISN associate chief nurse telehealth; the Chief of Staff; the acting chief of primary care (direct supervisor); the chief informatics officer; the telehealth chief; telehealth service manager; telehealth program coordinator; the telehealth coordinator primary care; pharmacists; a primary care clinical nurse leader; clinical informatics program analysts and primary care providers, including the subject provider.

[9] VA OIG, *Falsification of BP Readings at the Danville CBOC, Salem, Virginia*, Report 18-05410-62, January 29, 2019.

The OIG team reviewed relevant VHA directives and handbooks, clinical practice guidelines, patient EHRs, training documents, and electronic communication of facility leaders and staff. The OIG retrieved and reviewed patient data obtained from VHA's Corporate Data Warehouse.[10]

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 to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. 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.

Inspection Results

1. Provider Documented False Blood Pressures

The OIG determined that the provider knowingly documented false blood pressures in patients' EHRs during primary care VVC visits. The OIG found that the provider inaccurately stated that the false blood pressure entries were necessary due to a required field within the VVC template. The provider also inaccurately reported not being trained to use the VVC template. Although the provider reported using strategies to mitigate the impact of the false blood pressures, the OIG did not find evidence that the strategies were consistently used. The OIG reviewed a sample of patients' EHRs and did not identify adverse clinical outcomes that resulted from the false blood pressure documentation.

VHA expects providers to enter accurate information in EHRs and adhere to principles of ethical conduct including an effort to avoid actions creating even the appearance of a violation of law or ethical standards.[11] The American Medical Association's Principles of Medical Ethics notes dishonest conduct or incompetence of a physician poses real or potential threat to patients and is

[10] "Corporate Data Warehouse" (web page), Health Services Research and Development, accessed on June 13, 2022, https://www.hsrd.research.va.gov/for_researchers/vinci/cdw.cfm. The Corporate Data Warehouse is a large-scale data warehouse—a collection of healthcare data obtained from VHA's EHR system.

[11] 5 C.F.R. § 2635.101 (b)(14) (2022); VHA Directive 1907.01, *VHA Health Information Management and Health Records*, April 5, 2021; VHA Health Information Management Office of Health Informatics, "VHA Clinical Documentation Integrity Program Guide," January 2022.

"reprehensible."[12]

During interviews, providers indicated that if a provider does not observe the blood pressure, documentation would identify the blood pressure as self-reported in a progress note.[13] VHA requires providers to complete VA Talent Management System (TMS) courses prior to using VVC.[14] VHA directs providers to document observed blood pressures in the vital signs area of the EHR.[15]

Provider's Deficient Practice and Inaccurate Explanation

During interviews with the OIG, the provider admitted to routinely entering false blood pressures of 120/80 into EHRs for VVC visits, and neither confirmed nor denied if blood pressure numbers other than 120/80 were falsified when asked multiple times. Through a review of vital signs data from VHA's Corporate Data Warehouse, the OIG found that the provider had entered blood pressures of 120/80 for 312 patients from January 1, 2020, through January 12, 2022.[16] Although the provider attempted to explain that the VVC template and not receiving VVC training led to entering the false blood pressures, the OIG found that the provider's explanations were inaccurate.

VVC Template

Within the EHR, providers are able to develop and use shared templates to assist in efficiency and consistency of clinical documentation.[17] Some templates, or sections of templates, can be required, while others are optional.[18] During interviews, a clinical informatics program analyst confirmed the facility's VVC template is an optional template and contains a blood pressure field. Blood pressures entered into the blood pressure field are automatically transmitted to the vital signs portion of the EHR, which permits providers to track and trend a patient's blood

[12] American Medical Association, "Discipline & Medicine, Code of Medical Ethics Opinion 9.4.3," accessed April,6,2022, https://www.ama-assn.org/print/pdf/node/5631.

[13] "Telehealth Teleprimary Care" (web page), VHA Telehealth Services, accessed March 16, 2022, http://vaww.telehealth.va.gov/clinic/pri/tpcre/index.asp.

[14] VHA Deputy Under Secretary for Health for Operations and Management, "COVID-19: Protecting Veterans and the Department of Veterans Affairs (VA) Workforce by Leveraging Video Telehealth from VA Clinics and Home," memorandum.

[15] "Telehealth Teleprimary Care" (web page), VHA Telehealth Services.

[16] VA Health Services Research & Development Service, VA Information Resource Center, *VIReC Factbook: Corporate Data Warehouse (CDW) Vital Sign 1.1 Domain*, February 2018. Vital sign data do not have identifiers that link to a visit; as a result, VVC visits could only be confirmed through individual chart reviews.

[17] VA Office of Information and Technology, *Computerized Patient Record System (CPRS) User Guide: GUI Version,* January 2022. A template is an electronic form clinicians can use to enter text and other values into the electronic health record.

[18] VA Office of Information and Technology, *Computerized Patient Record System (CPRS) User Guide: GUI Version.*

pressure over time.[19] During an interview, a clinical pharmacist confirmed this information could be used to manage hypertension.

During an interview with the OIG, the provider attributed the falsifications to the belief that the facility VVC template required providers to document a false blood pressure when an actual blood pressure had not been obtained during the visit. The provider further represented to the OIG that other providers were experiencing the same issue and were also entering false blood pressures into the template. However, during an interview, the OIG asked the telehealth coordinator if the issue with the VVC note template was a user or template issue. The telehealth coordinator replied there were no issues with the template and that no other providers had problems with the note template.

Contrary to the provider's claim, the telehealth coordinator verbalized in an interview that the blood pressure area in the template could be left blank if a blood pressure was not observed during a visit. Providers explained that a patient-reported blood pressure could be documented in a progress note, reiterating that unobserved blood pressures should not be entered in the template. During the course of the inspection, the OIG observed the use of the template by clinical informatics program analysts and confirmed that use of the template was not mandatory and that providers were able to bypass entering blood pressures in the template.

The OIG concluded that the facility VVC template did not require the provider to document a false blood pressure; and, in doing so, the provider failed to adhere to VHA policies on documentation and ethical conduct.

VVC Training

The provider also attributed the falsifications to not receiving training for VVC visits. The OIG confirmed, however, that the provider completed required VVC training courses by April 1, 2020, prior to completing VVC visits.[20] The OIG was unable to access the previous VVC TMS training courses and requested the course information from the VISN Connected Care Program Manager, who reported an inability to access the previous TMS training courses. Therefore, the OIG could not confirm the training included information on entering blood pressures.

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[19] VA Office of Information & Technology Office of Enterprise Development, "Using Vitals in CPRS," chap. 8 in *VistA Vitals/Measurements User Manual GMRV 5.0-23*, October, 2002, rev. September 2009.

[20] VHA Deputy Under Secretary for Health for Operations and Management, "COVID-19: Protecting Veterans and the Department of Veterans Affairs (VA) Workforce by Leveraging Video Telehealth from VA Clinics and Home," memorandum. A provider is considered telehealth capable after completion of three TMS legacy courses including *Telehealth to Home Using VA Video Connect Provider training*, *Virtual Care Manager training*, and the *Telehealth Emergency Plans Memorandum Self-Certification*. "VA Video Connect Solutions" (web page), VHA Telehealth Services, accessed May 16, 2022, https://vaww.telehealth.va.gov/pgm/vvc/index.asp#fundamentals. Effective October 1, 2020, these trainings were combined into one course; providers who had not taken the legacy courses were required to complete the new training.

The OIG requested training requirements from the provider's direct supervisor that outline how providers visualize blood pressures during VVC appointments and document them in the vital signs package. In response, the provider's direct supervisor submitted an email that the provider's former direct supervisor sent to all primary care staff on December 23, 2020, explaining that a blood pressure entered into the VVC template would automatically transmit blood pressure results to the vital signs area of the EHR. The email also included instruction to contact the provider's former and current direct supervisor if blood pressure readings were not being captured during nursing pre-visit calls. The direct supervisor and another provider reported that the telehealth coordinator was available as a resource to staff to troubleshoot and navigate technical issues with the VVC template. Additionally, the telehealth coordinator reported presenting regularly at primary care meetings and sending email updates to other primary care providers regarding new information.

During an interview with the OIG on January 12, 2022, the provider reported documenting false blood pressures in the EHR for approximately two years and, while feeling uncomfortable with the practice, had not brought the issue to anyone's attention, and reported being unsure of whom to ask for assistance. During the interview, the provider reported questioning the practice after being contacted by the OIG for an interview for this healthcare inspection.

The OIG concluded that, while the mandatory training may not have addressed blood pressure entries during VVC visits, the provider had been emailed instructions regarding documenting blood pressures and had access to resources including supervisory staff and the telehealth coordinator who could have addressed questions or concerns. The provider failed to follow the instructions or seek assistance. The OIG determined that by falsifying blood pressures and not seeking assistance, the provider did not comply with VHA's documentation policy, violated ethical standards, and created a potential threat to patients.

Provider's Inconsistent Mitigation of Harm

During an interview with the OIG, the provider reported the belief that, even though blood pressures were falsified, patients were not harmed due to the use of mitigation strategies. The provider reported specific actions were taken to mitigate risks, including

- ensuring that "all" patients, even those without hypertension, were scheduled with or monitored by a clinical pharmacist for management of hypertension;
- sending "everyone" a blood pressure monitor; and
- indicating in progress notes that the blood pressures of 120/80 documented in the vitals package were inaccurate.

The OIG reviewed 67 of the 312 patient EHR that included a blood pressure of 120/80 to assess the validity of the provider's mitigation claims.[21] The OIG did not find the provider's claim of having a clinical pharmacist follow up, issuing blood pressure monitors, or documenting that the blood pressures were inaccurate had occurred with most of the patients reviewed. Specifically, the OIG found that

- 24 of 67 patients had a clinical pharmacist following the patient or a consult for hypertension or cardiovascular management,
- 9 of 67 patients had an existing blood pressure monitor or had one ordered by the provider, and
- No patient EHRs had documentation noting that the 120/80 blood pressure was inaccurate.

During interviews, the OIG found the provider's explanations for falsifying blood pressures for over two years to be inaccurate and claims of mitigation techniques were not confirmed by chart review. Further, the provider would not confirm or deny if blood pressures other than 120/80 had been falsely documented. Due to these actions, the OIG questioned the provider's competence and clinical judgment in completing primary care VVC visits.

Adverse Clinical Outcome Review

From the review of the 67 EHRs, the OIG found no adverse clinical outcomes resulted from the provider entering false blood pressures.[22] Although adverse clinical outcomes were not identified in the cohort reviewed, the OIG was unable to predict if the patients reviewed will have harmful effects in the future or the clinical impact for the remaining patients who were not reviewed by the OIG.

False blood pressures entered into the EHR have the potential for use by other medical staff caring for the patient and may provide a false sense of stabilization of a disease when in fact, the patient's disease processes may be deteriorating. Falsifying blood pressure numbers is a patient safety risk.[23]

While an accurate blood pressure is clinically important for all patients, false blood pressures are of particular concern for patients with certain medical conditions. Recording accurate blood pressures in the EHR is fundamental for hypertension management. Therefore, the OIG reviewed

[21] All 67 EHRs reviewed included a blood pressure of 120/80 documented during a VVC visit. Of the 67 EHRs reviewed, 17 were selected based on an emergency department visit that followed the false blood pressure entry while the remaining 50 were randomly selected for review.

[22] Within the context of this report, the OIG considered adverse clinical outcomes to be defined as death, hospitalization, or significant change in the status of a patient's disease, that in OIG's assessment, may have been preventable if the blood pressure was not falsified during the VVC visit.

[23] Computerized Patient Record System is the current VA Medical Record System utilized in the facility.

EHRs for specific elements, including establishing whether the provider documented management of hypertension, and determining if other providers utilized the false blood pressures up to 60 days after the visit.[24] Of the 67 EHRs, 33 patients had either established cardiovascular disease or hypertension, both of which are high-risk conditions that may require blood pressure monitoring.[25] The provider documented management of hypertension in 26 of these 33 EHRs. The OIG found three instances of the provider's documented blood pressure of 120/80 appearing in other providers' notes for follow-up visits; however, the false blood pressures were not used to make healthcare decisions.

The OIG concluded that no adverse clinical outcomes were identified through the review of the 67 EHRs. However, because other providers may rely on accurate blood pressures to make clinical decisions for rendering care, patients were placed at risk for improper management and monitoring of disease processes. Therefore, the OIG remains concerned about future impact on the patients reviewed and overall impact on patients who were not reviewed, including those who may have had false blood pressures other than 120/80 documented.

2. Facility Leaders' Response to Falsification of Blood Pressures

Although facility leaders took action upon the OIG alerting them to the physician's practice of entering false blood pressures, the OIG found inadequacies with the facility leaders' response. Specifically, facility leaders instructed the provider to stop entering false blood pressures, retrained the provider on VVC documentation procedures, notified Human Resources of the potential need for disciplinary action, and completed a focused professional practice evaluation for cause. However, the OIG found that facility leaders failed to comply with VHA policy to initiate reporting to the state licensing board(s) based on the provider's admission to entering false blood pressures in EHRs. Additionally, facility leaders completed an EHR review of the provider's VVC visits. However, the OIG analyzed the facility's EHR review and found that not all EHRs were reviewed and amended as attested by facility leaders.

VA policy requires facility leaders to facilitate prompt corrective actions when an employee fails to maintain high standards of integrity, conduct, or effectiveness.[26] Per VHA, facility leaders may initiate a management review such as a focused clinical care review when there is an

[24] The OIG review included modifications to medication orders, referrals, and consults for cardiovascular management.

[25] Nada El Husseini, Omran Kaskar, and Larry B. Goldstein, "Chronic Kidney Disease and Stroke," *Advances in Chronic Kidney Disease* 21, no. 6 (November 2014): 500-508. The OIG defined established cardiovascular disease as having coronary artery disease, myocardial infarction, history of stroke, or congestive heart failure, including conditions that are associated with vascular diseases such as chronic kidney disease.

[26] VA Handbook 5021/22, *Employee/Management Relations*, March 14, 2016.

identified concern or issue.[27] This review of the clinician's practice may be used to determine what future actions may be taken, including a focused professional practice evaluation for cause.[28] Further, VHA policy requires providers who "failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients or the community" be reported to the state licensing board.[29] The state licensing board reporting process is not dependent on the privileging action but rather evidence of substandard care.[30]

VHA also requires false patient health information in EHRs to be corrected and outlines specific steps for correcting an erroneous vital sign entry.[31] To ensure that erroneous vital sign data are not displayed, the item must be marked as "entered in error" in the vital sign package.[32]

Clinical and Administrative Actions

The Chief of Staff reported first learning of the provider falsifying blood pressures during an interview with the OIG on January 13, 2022. The Chief of Staff issued a cease-and-desist order to the provider on January 13, 2022, which specified that the provider was to no longer enter vital signs that had not been taken, then met with the provider's direct supervisor, and initiated consultation with Human Resources regarding potential disciplinary action. Notably, the Chief of Staff and direct supervisor reported that prior to this inspection, no concerns regarding the provider's clinical practice had been identified.

During an interview with the OIG, the direct supervisor reported speaking with the provider in mid-January and reinforcing the Chief of Staff's order to no longer enter false blood pressures. Additionally, the direct supervisor scheduled the provider for an all-day training session for January 27, 2022, with the telehealth coordinator. According to the direct supervisor, after completing the training, the provider demonstrated the correct use of the VVC template. The direct supervisor reported verifying with the provider the steps to complete the VVC template without entering a blood pressure.

On January 31, 2022, the OIG conducted a follow-up interview with the provider. The provider reported learning "a whole lot from it [VVC training]." However the OIG was concerned that the

[27] VHA Directive 1190, *Peer Review for Quality Management,* November 21, 2018. A focused clinical care review "is a clinician-specific comprehensive clinical care review of a specific area of practice, a specific time period of practice, or both, when there is an identified concern or issue." The chief of quality, safety, value told the OIG that this review did not have a specific title; however, the OIG noted that the review met VHA's definition of a focused clinical care review.

[28] VHA Directive 1190. A focused professional practice evaluation for cause is designed to allow providers an opportunity to improve an identified clinical concern.

[29] VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021.

[30] VHA Directive 1100.18.

[31] VHA Directive 1907.01, *VHA Health Information Management and Health Records,* April 5, 2021; VA Office of Information & Technology Office of Enterprise Development, "Using Vitals in CPRS."

[32] VA Office of Information & Technology Office of Enterprise Development, "Using Vitals in CPRS."

provider took multiple attempts to locate the facility VVC template and had difficulty utilizing the camera.[33] Therefore, based on the provider's demonstrated technology challenges, the OIG had continued concerns regarding the provider's ability to successfully complete primary care VVC visits.

The OIG asked the direct supervisor and the Chief of Staff whether they had concerns about the provider's judgment. The direct supervisor acknowledged concern as to why the provider did not reach out to management or the telehealth coordinator. The Chief of Staff voiced concerns that the blood pressure falsifications could be considered illegal. The Chief of Staff confirmed that Human Resource actions and consultation with the Office of General Counsel were being considered.

On March 14, 2022, the direct supervisor initiated a focused professional practice evaluation for cause. The Chief of Staff notified the OIG on June 10, 2022, that the provider successfully completed the focused professional practice evaluation for cause demonstrating correct documentation practices for entering vital signs. Despite the provider previously admitting to the practice of entering false blood pressures, the Chief of Staff informed the OIG that the reporting process was not initiated to the state licensing board since the provider successfully completed the focused professional practice evaluation for cause, through which performance was reviewed and monitored over a 90-day period.

The OIG concluded that facility leaders initiated actions upon learning of the falsification of blood pressures that included requiring the provider to stop the practice, consulting with Human Resources for disciplinary action, providing an all-day training, and completing a focused professional practice evaluation for cause. Although an all-day training was conducted and the provider demonstrated improved documentation practices through the focused practice evaluation for cause, the OIG remains concerned for the provider's competence to complete primary care VVC visits as the provider continued to display difficulty demonstrating the use of technology and locating the VVC template. Further, facility leaders failed to initiate the state licensing board reporting process, despite the provider admitting to the practice of entering false blood pressures.

Inadequacies Identified Within Facility EHR Review

The direct supervisor reported initiating an EHR review of the provider's VVC visits and tasked the provider to place an addendum in the patients' records to identify erroneous blood pressures. The chief of quality, safety, value (QSV chief) directed a staff nurse to conduct the EHR review. At the request of the OIG team, the QSV chief provided the review criteria and findings. The

[33] The camera is the primary equipment on the provider's computer that allows the patient and provider to view each other during a VVC visit, and required for the provider to use in verification that the correct blood pressure measurement is entered into the medical record.

QSV chief reported that

- a staff nurse reviewed 657 EHRs representing all of the provider's VVC visits that occurred from March 1, 2020, through March 8, 2022;
- 276 patients had a documented erroneous blood pressure entry of 120/80;
- the staff nurse completed this review on March 18, 2022, and found no evidence of adverse clinical outcomes;
- the Deputy Chief of Staff reviewed EHRs of expired patients and found no correlation to false blood pressures.

The OIG analyzed the facility's EHR-review data and determined the facility's review and amendment process to be inadequate in addressing the falsification of blood pressures. On May 13, 2022, the OIG evaluated a sample of 100 patients identified in the facility's EHR review and found that 19 patients with a blood pressure of 120/80 were not clinically reviewed or amended, despite the attestation from facility leaders. The acting chief of primary care was unable to provide the rationale as to why all EHRs were not clinically reviewed or amended when asked by the OIG. Further, according to the QSV chief, the staff nurse only reviewed patients with an erroneous blood pressure measurement of 120/80.

The QSV chief reported that the provider entered an addendum to each EHR entry that contained an erroneous blood pressure of 120/80 to reflect the blood pressure was false. The OIG verified that an addendum had been placed on at least five of the identified patients stating that the blood pressure measurement was documented "inadvertently;" however, since the falsified blood pressures were not specifically corrected, they remain as vital signs in the official medical record and are available for use in clinical decision-making.

The OIG concluded that although facility leaders initiated a review of the provider's EHR entries for VVC visits, not all EHRs were reviewed. Additionally, the provider's amendments to EHR entries did not ensure that the falsified blood pressures were not used for clinical decision-making.

Conclusion

The provider documented false blood pressures in patients' EHRs during primary care VVC visits for approximately two years. Although the provider attributed the entry of false blood pressures to an issue with the VVC template, the OIG found no support for the provider's claim. Likewise, the OIG found that the provider's rationale of not receiving VVC training was inaccurate as the OIG's inspection revealed the provider had completed VVC training. While the mandatory VVC training may not have specifically addressed blood pressure entries, the provider failed to access available resources such as the direct supervisor or telehealth coordinator, or seek further assistance.

The provider had entered the blood pressure of 120/80 for 312 patients from January 1, 2020, through January 12, 2022. The provider reported the belief that, even though blood pressures were falsified, patients were not harmed due to the use of mitigation strategies. The OIG reviewed 67 of the 312 patients' EHRs with documented blood pressures of 120/80 and found that the provider's claim of mitigation efforts had not occurred with most of the patients reviewed.

The OIG reviewed 67 of the provider's EHR entries of VVC visits and did not identify adverse clinical outcomes. Because other medical providers may rely on accurate blood pressures to make clinical decisions for rendering care, patients were placed at risk for improper management and monitoring of disease processes.

Facility leaders initiated actions upon learning of the falsification of blood pressures that included requiring the provider to stop the practice, consulting with Human Resources for disciplinary action, providing an all-day training, and completing a focused professional practice evaluation for cause. Although an all-day training was conducted and the provider demonstrated improved documentation practices through the focused practice evaluation for cause, the OIG remains concerned for the provider's competence to complete primary care VVC visits as the provider continued to display difficulty demonstrating the use of technology and locating the VVC template. Further, facility leaders failed to initiate the state licensing board reporting process, despite the provider admitting to the practice of entering false blood pressures. The OIG concluded that although facility leaders initiated a review of the provider's EHR entries for VVC visits, not all EHRs were reviewed. Additionally, the provider's amendments to EHR entries did not ensure that the falsified blood pressures were not used for clinical decision-making.

Recommendations 1–5

1. The North Las Vegas Medical Center Director ensures, through training and observation, that the primary care provider is competent completing and documenting primary care VA Video Connect visits.

2. The North Las Vegas Medical Center Director considers taking administrative action in relation to the primary care provider, as appropriate.

3. The North Las Vegas Medical Center Director considers the need to initiate reporting the primary care provider to the state licensing board and takes action as necessary.

4. The North Las Vegas Medical Center Director ensures a review is conducted of the primary care provider's electronic health record documentation in order to determine if blood pressure entries other than 120/80 are false and takes action as necessary.

5. The North Las Vegas Medical Center Director ensures that any identified false blood pressures are amended in the electronic health record in accordance with Veterans Health Administration policy.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: December 8, 2022

From: Director, Sierra Pacific Network (10N21)

Subj: Healthcare Inspection—Physician's Falsification of VA Video Connect Blood Pressures at the North Las Vegas VA Medical Center in Nevada

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

1. I have reviewed and concur with the responses provided by the North Las Vegas VA Medical Center.

2. If you have any additional questions or need further information, please contact the VISN 21 Quality Management Officer.

(*Original signed by:*)

John Brandecker, MBA, MPH
Network Director

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: December 1, 2022

From: Director, VA Southern Nevada Healthcare System (593)

Subj: Healthcare Inspection—Physician's Falsification of VA Video Connect Blood Pressures at the North Las Vegas VA Medical Center in Nevada

To: Director, Sierra Pacific Network (10N21)

1. We appreciate the opportunity to review the draft report of recommendations from the OIG Health Care virtual inspections conducted at the VA Southern Nevada Healthcare System from January 10–20, 2022. Additional interviews were conducted through March 2, 2022.

2. Please find the attached response to each recommendation included in the report. We have completed, or in the process of completing, actions to resolve these issues.

(*Original signed by*:)

William J. Caron, PT, MHA, FACHE
Medical Center Director/CEO
VA Southern Nevada Healthcare System

Facility Director Response

Recommendation 1

The North Las Vegas Medical Center Director ensures, through training and observation, that the primary care provider is competent completing and documenting primary care VA Video Connect visits.

Concur.

Target date for completion: February 15, 2023

Director Comments

The North Las Vegas Medical Center Director ensured, through training and observation, that the primary care provider is competent completing and documenting primary care VA Video Connect visits. The primary care provider was retrained by the telehealth coordinator on VVC operation and documentation on January 27, 2022. Additionally, the Chief of Primary care coordinated with the Clinical Applications Coordinator (CAC) team member to train the primary care provider on appropriate utilization of a VVC note. The Chief of Primary Care or designee will observe 5 VVC visits per month including vital sign documentation review, if vital signs were taken, for the next 2 months to ensure that the primary care provider continues to operate and document in the VVC template appropriately. Also, the Physician Supervisor of the Southwest Clinic will review a sample of 10 additional medical records (VVC visits) from Quarter 4 2022 for complete and appropriate vital sign documentation, if vital signs were taken.

Recommendation 2

The North Las Vegas Medical Center Director considers taking administrative action in relation to the primary care provider, as appropriate.

Concur.

Target date for completion: May 5, 2022

Director Comments

The North Las Vegas Medical Center Director took appropriate administrative actions at the time these concerns were identified. On January 13, 2022, the Chief of Staff issued a direct order to the provider to cease and desist this practice, as entering vitals that were not performed is considered falsification of the medical record. The cease and desist served as the initial HR action. Additionally, the Chief of staff met with the provider's direct supervisor, and initiated consultation with Human Resources regarding potential disciplinary action.

On March 14, 2022, a focused professional practice review for cause (FPPE) was initiated as a

result of inaccurate documentation of blood pressures in patients charts during VVC visits. The FPPE for cause reviewed medical records to evaluate documentation of vital signs, if taken, were completed appropriately. On March 23, 2022, the Chief of Primary Care required the provider to place an addendum into the affected medical records that contained the erroneous blood pressures that stated, "Blood pressure entered inadvertently during this VVC visit." The provider completed the addendums into the affected medical records on March 25, 2022.

On May 5, 2022, the provider successfully completed the FPPE for cause demonstrating correct documentation practices for entering vital signs, if taken. The Chief of Primary Care also conducted weekly meetings with the provider to ensure compliance throughout the duration of the FPPE for cause.

OIG Comments

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 3

The North Las Vegas Medical Center Director considers the need to initiate reporting the primary care provider to the state licensing board and takes action as necessary.

Concur.

Target date for completion: December 15, 2022

Director Comments

Review of the medical records showed there were no medical/clinical decisions made based upon these erroneous blood pressures. Further review of these medical records also showed that there were no adverse events. Based upon the practice of documenting erroneous blood pressures, it was decided to report the provider to the State Licensing Board as VASNHS does not consider this an acceptable documentation practice. Also of note, these VVC visits occurred during the COVID-19 pandemic where expansion of VVC visits were offered to avoid cancelling patient care. Because of this, there were a myriad of changes in hospital operations, including provider documentation and utilization of new templates in the electronic health (EHR) record during this time. The provider thought the field in the template was a "hard stop" or required element in order to exit the template. Appropriate training and monitoring of the providers' practice was conducted as previously described.

OIG Comments

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 4

The North Las Vegas Medical Center Director ensures a review is conducted of the primary care provider's electronic health record documentation in order to determine if blood pressure entries other than 120/80 are false and takes action as necessary.

Concur.

Target date for completion: March 25, 2022

Director Comments

A nurse at VASNHS reviewed all of the VVC visits for any blood pressure entries over the last 2 years, 3/1/2020-3/8/2022, which consisted of 657 total VVC visits.

There was a total of 276 that had documented erroneous blood pressures. The nurse's review was completed on March 18, 2022. The provider placed an addendum as previously described into the appropriate medical records of patients that had blood pressures that were entered erroneously. This was completed on March 25, 2022. None of the VVC visits had the capability to perform blood pressures; therefore, any blood pressures that were documented were erroneous.

Additionally, on April 4, 2022, the Deputy Chief of Staff reviewed the 4 patients that had expired (out of the 276) during this time and there was no correlation between the death and documentation of the erroneous blood pressure at the VVC visit.

OIG Comments

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 5

The North Las Vegas Medical Center Director ensures that any identified false blood pressures are amended in the electronic health record in accordance with Veterans Health Administration policy.

Concur.

Target date for completion: January 31, 2023

Director Comments

The North Las Vegas Medical Center Director will ensure that any identified false blood pressures are amended in the EHR in accordance with Veterans Health Administration policy. The 276 medical records that had documented erroneous blood pressures will be re-reviewed by

Primary Care Service and the provider will enter the appropriate addendum for any medical records that may have been missed during the initial review.

Glossary

To go back, press "alt" and "left arrow" keys.

chronic kidney disease. A decline in kidney function resulting in a decreased ability of the kidneys to filter waste and remove excess fluids from the blood through the urine, resulting in a buildup of fluid and waste in your body.[1]

diastolic blood pressure. "The pressure in the arteries when the heart is resting between beats."[2]

heart failure. Also referred to as congestive heart failure, "occurs when the heart muscle doesn't pump as well as it should," which can lead to blood and fluid backing up into lungs causing breathing difficulty.[3]

hypertension. Also called high blood pressure, occurs when the blood moves through the arteries at a higher pressure than normal. Uncontrolled hypertension can lead to complications that include stroke, heart failure, heart attack, and impaired kidney function.[4]

stroke. An emergency condition that occurs "when the blood supply to part of the brain is interrupted or reduced," depriving brain tissue of oxygen and nutrients.[5]

systolic blood pressure. Pressure in the arteries when the heart is beating and the arteries are filled with blood.[6]

VA Talent Management System. The VA central software system used for online tracking and managing of training required for VA employees.[7]

vital sign package. An application within the electronic health record that specifically stores vitals sign measurements in a repository to support clinical documentation. The data remain stored in the vital signs package.[8]

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[1] Mayo Clinic, "Chronic kidney disease," accessed August 23, 2022, https://www.mayoclinic.org/diseases-conditions/chronic-kidney-disease/symptoms-causes/syc-20354521.

[2] Cleveland Clinic, "diastolic blood pressure," accessed August 23, 2022, https://my.clevelandclinic.org/health/diseases/17649-blood-pressure.

[3] Mayo Clinic, "Heart failure," accessed March 24, 2022, https://www.mayoclinic.org/diseases-conditions/heart-failure/symptoms-causes/syc-20373142.

[4] Mayo Clinic, "High blood pressure (hypertension)," accessed July 21, 2022, https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/symptoms-causes/syc-20373410.

[5] Mayo Clinic, "Stroke," accessed March 24, 2022, https://www.mayoclinic.org/diseases-conditions/stroke/symptoms-causes/syc-20350113.

[6] Cleveland Clinic, "systolic blood pressure," accessed August 23, 2022, https://my.clevelandclinic.org/health/diseases/17649-blood-pressure.

[7] VA Directive 0004, *Education and Learning Delivery System*, April 20, 2012.

[8] VistA Vitals/Measurements User Manual GMRV 5.0-23, "Using Vitals in CPRS."

OIG Contact and Staff Acknowledgments

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