DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

PODCAST TRANSCRIPT

Falsification of Blood Pressure Readings at Two Community Based Outpatient Clinics in Kentucky and Virginia

March 14, 2019

Vickie Coates:

This is Vickie Coates, director of the Office of Healthcare Inspection's Rapid Response team. I'm speaking with Dr. Thomas Wong, with the OIG's medical consultation team, about two recent OIG reports concerning the falsification of blood pressure readings at VA Community Based Outpatient Clinics also called CBOCs.

These two reports, released in September 2018 and January 2019, illustrate important quality of care issues discovered at the Berea CBOC in Lexington, Kentucky, and the Danville CBOC in Salem, Virginia. In the case of Berea, the CBOC leadership reported the repeating blood pressure readings to the Lexington VA Medical Center and an OIG nationwide search for providers documenting the same blood pressure readings identified possible falsified readings at the Danville CBOC. As we all know, the falsification of blood pressure readings can affect the appropriate diagnosis, evaluation, and treatment of patients with hypertension.

Dr. Wong can you tell us more about what it means to have high blood pressure and why close monitoring is so important?

Dr. Thomas Wong:

Certainly. Let me start by explaining that high blood pressure, also known as hypertension, is a condition that occurs because the force of blood pushing against the walls of the blood vessels is consistently too high.

Normal blood pressure is generally considered to be less than or equal to 120/80. A patient's blood pressure is considered "elevated" if consistently recorded higher than that. A patient with a consistently elevated blood pressure of 140/90 or higher is given a diagnosis of hypertension.

High blood pressure is frequently called "the silent killer" because patients with hypertension frequently lack symptoms that would alert them to dangerously high blood pressure. This is an important point because when blood pressure is not controlled, patients are at higher risk for heart attack, stroke, kidney disease, heart failure, and death.

As a result, routine screening of all patients and close monitoring of patients with high blood pressure is crucial in preventing these types of adverse health events.

Vickie Coates:

So, what happened at the Berea and Danville CBOCs?

Dr. Thomas Wong:

When a patient comes to the clinic for an appointment, a member of the nursing team will escort the patient to an exam room, ask about the reason for the visit, and take their vital signs. Taking vital signs usually includes documenting the patient's temperature, pulse rate, and blood pressure.

Accurately documenting the patient's vital signs is a critical first step in caring for the patient. The information is documented in the patient's medical record and is available for the physician to review and can influence the decisions made on how to manage the patient's condition. For example, if the patient has no previous history of high blood pressure and the vital signs reveal an elevated reading, the physician may ask if the patient is anxious or in pain. If the patient has high blood pressure and is taking medication to control it, the physician will ask if the patient is taking the medications. Regardless of the reason for the elevated blood pressure reading, at both CBOC's the nursing staff was required to retake the patient's blood pressure, document the initial and repeat readings; and notify the physician of any abnormal finding.

With that background, we were obviously concerned when we found out that physicians at the Berea and Danville CBOCs may have falsified the blood pressure documentation in the records of patients with initially elevated readings. Specifically, for patients with initially and in some cases, repeat elevated blood pressure readings, the physicians documented the patients' repeat blood pressures as normal.

Vickie Coates:

So, the blood pressure was recorded as elevated but after the provider evaluated the patient, a normal reading was entered into the record?

Dr. Thomas Wong:

Yes, we found that at both CBOCs, the physicians consistently falsified patients' blood pressure readings. Additionally, we found that neither physician consistently added or changed patient medication when needed, ordered additional laboratory work, or had patients return for follow-up appointments at a frequency consistent with appropriate management of the patient's diagnosis or blood pressure readings.

Vickie Coates:

Were any patients harmed?

Dr. Thomas Wong:

At the Berea CBOC we identified several patients that experienced poor care or negative outcomes, including an acute cardiac event. Additionally, three specific cases were identified where patients either experienced negative outcomes or were at high risk for negative outcomes because the physician did not properly manage the patient's blood pressure.

Although we did not identify any specific adverse patient events at the Danville CBOC, we did find that the physician failed to adequately manage patients with historically high blood pressures. This placed these patients with or without risk factors a potential risk for future adverse health outcomes.

Vickie Coates:

How did this happen?

Dr. Thomas Wong:

There are several similarities and distinct differences between what happened at the two facilities. Let's start with the differences. At the Lexington CBOC it appeared that the provider wanted to "turn off" the clinical reminder; alerts that appear on the front page of the health record. They remind the provider that additional tests or consults may be needed for that patient.

In the case of a patient with high blood pressure, the clinical reminder "pops up" and the provider is prompted at that point to decide if a change to the patient's medication, additional laboratory tests, or referrals to other specialists are needed. The provider can choose to ignore the clinical reminder if the patient's condition does not require any changes. Now this is the interesting point here—by entering a "normal" blood pressure, the clinical reminder goes away and the provider is no longer required to document any additional interventions. In the circumstance of Lexington, the physician told the OIG team the blood pressure clinical reminder was an annoyance. To turn it off, the physician would enter a normal blood pressure value; in this case 128/78. The reminder disappeared and the physician was not required to do anything else.

At the Danville CBOC, the issue was a bit different. The physician told the OIG team that either during or at the end of the patient visit, he personally repeated the blood pressures for patients with initially elevated readings. The physician also told us that because he did not write down the readings, or immediately record them in the patient's record, by the time he was able to make an entry into the record, he sometimes "forgot" what the actual reading was. He would then document a blood pressure reading that was just below 140/90; in this case 139/89. Interestingly, the physician acknowledged that falsifying the blood pressure readings was not the right thing to do; however, he did not feel this practice compromised patient care.

Now for the similarities. In both cases, the physician documented in the medical record falsified blood pressure readings for patients whose blood pressures were initially elevated at the time of their clinic appointment. At both CBOCs, patients did not have their hypertension appropriately managed, and

regardless of their individual conditions, all were potentially placed at risk for future adverse health outcomes. Finally, the falsified documentation impacted hundreds of patients and had been going on for years.

Vickie Coates:

You discussed what the physicians did and what their motivations may have been. What about facility leaders and managers? Was there something they could have or should have done to identify this problem?

Dr. Thomas Wong:

The OIG team discovered distinct differences between the two CBOCs in terms of why it happened. We also found similarities that helped us to identify possible interventions to prevent it from happening again.

At the Lexington CBOC, staff members reported the problem to facility leadership. Leadership notified the OIG, removed the provider from direct patient care, and initiated a very comprehensive review of the providers' actions. That was not the case at the Danville CBOC. Staff members with knowledge of the falsified documentation did not report it to appropriate facility leadership. Also, once the OIG team alerted the Danville facility leadership about the issue, they were slow to respond and did not implement a review of the physician's actions until prompted by the OIG to do so.

The OIG team is uncertain as to why one group of staff members chose to report the issue to their leadership and another group did not. Or why the leadership for one CBOC initiated a robust review and the response from the other CBOC's leadership was less so. However, what is important to remember is that regardless of their individual roles or positions, staff are required to report patient safety issues. Leadership is required to be responsive to patient safety concerns, and to do what is necessary to ensure patients receive appropriate care.

Neither facility had processes in place to validate the accuracy of provider performance measure data. Let me explain that further. Facilities identify a variety of health outcome metrics used to evaluate individual providers performance. The care of patients with hypertension, including evaluating a provider's care in terms of how well the patients high blood pressure is being managed, is one of those measures. In the case of the hypertension measures, the data used to evaluate the providers performance comes directly from the documentation entered into the patients' health record. If a provider's hypertension metrics indicate success with managing their patient's high blood pressure, a provider may receive a monetary performance award. Ultimately, success with the management of hypertension, as evidenced by the metric, allows the provider to renew clinical privileges.

So, the point here is, if the provider documented falsified blood pressure readings, in the health record, the data used to evaluate how well or how poorly the patient's blood pressure is controlled is false. Without a method to validate the accuracy of what is recorded in the health record, falsification of documentation can occur and go undiscovered.

A visual scan of patient-level data for both providers would have revealed the pattern of repeat BPs being systematically documented as 128/78 by the Lexington physician and 139/89 by the Danville physician. Further, a basic comparison with other providers at the respective CBOCs may have raised flags.

Vickie Coates:

You covered a lot during this brief session. Now what? What can VHA do?

Dr. Thomas Wong:

The OIG made specific recommendations based on the unique issues identified at the respective CBOCs. One recommendation—ensuring that all patients actually or potentially impacted by the falsified documentation be reevaluated—was central to both CBOCs. Leadership for the Lexington CBOC had already taken steps to have their patients reevaluated and assigned to a new provider prior to the publication of that report. At the time we published the Danville report, leadership was in the process of implementing a process to contact the CBOC's patients and ensure they receive the appropriate follow up. Finally, the OIG team found the action plans and timelines submitted by the leadership for the remaining recommendations unique to the individual CBOCs to be appropriate.

Vickie Coates:

Is this something that could happen in other VHA facilities?

Dr. Thomas Wong:

Unfortunately, yes. However, with the publication of these reports, we hope that the leadership at all VHA facilities will take note of the findings and recommendations, assess their individual potential vulnerabilities, and take appropriate proactive actions.

Vickie Coates:

Any last thoughts?

Dr. Thomas Wong:

Patients who have entrusted their care through VA deserve to have providers who can deliver that care in the most ethical way possible. Patients trust that ethical practice occurs throughout the patient-provider relationship. If this trust is broken, that relationship is eroded and is potentially irreversible. Because VHA values the patient-provider relationship, it is important for our listeners to know that the two physicians at the center of these reports are no longer providing care to VA patients.

Vickie Coates:

Thank you, Dr. Wong.

OIG podcasts are produced by OIG staff and are available on the OIG's website.

To report fraud, waste, abuse, or possible criminal activity you can also visit our website at W-W-W dot V-A dot G-O-V slash O-I-G.