

Department of Veterans Affairs

Memorandum

Date: March 7, 2017

From: Assistant Inspector General for Investigations (51)

Subj: Administrative Investigation – Alleged Misuse of Official Time, Falsified Documents, Conflict of Interest, and Quality of Care, Birmingham VA Medical Center (VAMC), Birmingham, AL (2015-01328-IQ-0008)

To: Director, Birmingham VA Medical Center

Purpose

VA Office of Inspector General (OIG) Hotline received and referred to OIG Administrative Investigations Division, allegations that Dr. (b) (6), (b) (7)(C) (b) (6), Oral & Maxillofacial Surgery, VAMC Dental Service, misused her official time when she reported late for work; falsified documents when she manipulated appointment logbooks; engaged in a conflict of interest when she performed non-VA work during her VA tour of duty; and, improperly used an animal bone in a dental procedure after the patient declined the procedure due to religious beliefs.

Objective, Scope, and Methodology

To assess these allegations, we interviewed Dr. (b) (6) and VA and non-VA employees. We also reviewed email, personnel, time and attendance, and other records, as well as Federal laws, regulations, and VA policy.

Standards of Ethical Conduct for Employees of the Executive Branch state employees shall put forth an honest effort in the performance of their duties. 5 CFR § 2635.101(b) (5). An employee shall use official time in an honest effort to perform official duties. 5 CFR § 2635.705.

VA policy states that employees are expected to be on duty during the full period of their tours of duty unless absent on approved leave and to observe the opening and closing hours established for the tour of duty. VA Directive 5011/2, Para. 2d, (June 16, 2004).

Results

Issue: Did Dr. (b) (6), (b) (7)(C) Misuse Official Time, Falsify Documents, Engage in a Conflict of Interest, and Create a Quality of Care Issue?

Alleged Misuse of Official Time

Personnel records reflected that Dr. (b) (6), (b) (7)(C) began her VA career in (b) (6), (b) (7)(C), as the VAMC (b) (6), (b) (7)(C) Oral & Maxillofacial Surgery. In her position, she provided oral surgery consultation and treatment, evaluated patients for admission, and supported the training of (b) (6), (b) (7)(C) residents.

Time and attendance records and Dr. (b) (6), (b) (7)(C), Chief of Dental Service, identified Dr. (b) (6), (b) (7)(C)'s duty hours as Monday to Thursday, 7:00 a.m. to 5:00 p.m.; however, Dr. (b) (6), (b) (7)(C) said that she worked Monday to Thursday between 7:00–7:30 a.m. and between 4:00–6:00 p.m., depending on the volume of cases. Dr. (b) (6), (b) (7)(C), acting Chief of Dental Service from November 2012 to March 2014, told us that some of the staff complained that Dr. (b) (6), (b) (7)(C) was not always around when needed. Dr. (b) (6), (b) (7)(C) said that because Dr. (b) (6), (b) (7)(C)'s administrative office was on the 5th floor, versus the 1st floor dental clinic, it made it difficult for him to witness Dr. (b) (6), (b) (7)(C)'s day-to-day activities. However, he said that he never suspected Dr. (b) (6), (b) (7)(C) misused her official time.

Ms. (b) (6), (b) (7)(C), Dental Assistant, said that by 7:30 a.m., the first patient was usually prepared for sedation, and when staff called Dr. (b) (6), (b) (7)(C), she was available and reported to the clinic. Ms. (b) (6), (b) (7)(C) said that based on hearsay, some of the “residents” complained about Dr. (b) (6), (b) (7)(C) being late. However, Dr. (b) (6), (b) (7)(C) performed morning “rounds” to check on patients, which, at times, caused her to arrive late to the clinic. Ms. (b) (6), (b) (7)(C), Staff Nurse, told us that some of the staff reported late, but Dr. (b) (6), (b) (7)(C) did not fall into that category.

Dr. (b) (6), (b) (7)(C) said if a supervisor or staff member did not see her in the dental clinic at 7:30 a.m., it was because she reported to her office first. In regard to the residents' complaints, Dr. (b) (6), (b) (7)(C) said that the residents came from the University of Alabama (UAB), each month a new resident arrived, and the resident needed to learn how the clinic worked. Dr. (b) (6), (b) (7)(C) said she did not go to the clinic and sit from 7:00–8:00 a.m. and wait for surgery. Instead, she reported to her office, made rounds, or got ready for the clinic. She acknowledged her “mobile” status, but the residents remained able to contact her via pager. She said that until the new residents got adjusted, an individual possibly experienced a general sense of frustration at the beginning. However, she told us that these complaints were not voiced to her by her supervisors.

Dr. (b) (6), (b) (7)(C) said that he did not know whether Dr. (b) (6), (b) (7)(C) reported late for duty on a daily basis, in part, because “I have not been glued to monitoring her coming and going.” He said that none of her past or current VA timekeepers complained to him about her reporting late for duty. He said that since his arrival, he never questioned Dr. (b) (6), (b) (7)(C) about her unavailability during her VA tour of duty. We interviewed four additional individuals

who worked with Dr. (b)(6), and none provided any evidence to support a misuse of official time.

Additionally, Dr. (b)(6) told us that her staff consistently stayed late and earned a lot of compensatory time, as they frequently worked past 4:00 p.m. to finish with the patients. Dr. (b)(6) said if she remained unable to complete a procedure safely, with a given amount of medication, she sometimes staged/shortened the procedure for medical reasons, but she never witnessed or ordered a shortened procedure to avoid overtime.

False Documents

Federal statute states that whoever, in any matter within the jurisdiction of the executive, legislative, or judicial branch of the government of the U.S., knowingly and willfully makes or uses any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry shall be fined or imprisoned as provided in the federal statute, 18 USC § 1001(a)(3).

VA policy states that the public interest requires the maintenance of high standards of employee integrity, conduct, effectiveness, and service to the public and that when such standards are not met, it is essential that prompt and just corrective action be taken. VA policy is to maintain standards of conduct and efficiency that will promote the best interests of the service. VA Handbook 5021/3, Part I, Chapter 1, Paragraph 3(a) (June 1, 2005).

An April 2011 Memorandum on Prohibition of Written Logbooks issued by the then Assistant Secretary for Information and Technology called for the immediate ban on the use of physical logbooks that contain sensitive personal information (SPI) in VA facilities. Physical logbooks were defined as any written record of activity or events comprised of data which may uniquely identify an individual or contain SPI, and maintained over a period of time for the purpose of tracking information. When a VA organization deemed it necessary to create a logbook to satisfy a business requirement, all efforts should be made to maintain the log in electronic format on a certified and accredited VA system. The exceptions to this policy were when a compelling business need for a physical logbook was identified as being necessary to the success of the mission of the VA or when no other alternative could be achieved. These physical logbooks required approval from the facility director in accordance with local policy and approved processes.

A VAMC logbook request, dated July 19, 2013, reflected that the Dental Service, Department of Prosthodontics received approval for a patient assignment logbook. The logbook contained the patient's SPI, date assigned to a doctor, and whether the patient was scheduled for an evaluation. The compelling business need for this logbook was that the prosthodontics department received referrals from other departments within the Dental Service on a daily basis for patients requiring evaluations and treatment. Because the demand for these services remained so heavy, the patient assignment log provided the staff in the prosthodontics office a means to track the referred Veteran and

assign the Veteran to a provider in an orderly fashion. The request noted, "This has been the best way we have found of ensuring that referred Veterans don't 'fall through the cracks' and get forgotten."

Dr. (b) (6) told us that VAMC used VistA as its electronic scheduling system and it was an antiquated systems with limited functionalities, such as it did not trace the treatment patients were to receive - implant, extraction, retroplasty, surgery type; and it did not allow the users/providers to look at the data retroactively, which meant providers could not verify a patient's history. Dr. (b) (6) also told us that the entire dental service, to include her division, used government issued appointment books since she did her residency at VA in (b) (6). The appointment books allowed them to log as much information as possible related to the Veterans' treatment and provided a description of the patient's procedure and the time of their appointment. She said that the assistant then entered this information into VistA. Dr. (b) (6) agreed that the process was double work, but was more efficient than just using VistA, and she said that "Every clinic [did] it that way. So we had no variation at all."

Dr. (b) (6), (b) (7)(C), who served as Interim Dental Service Chief from March 2014 to December 2014, said even after the VistA scheduling package became available, the use of paper appointment books continued to be used as a supplement to the VistA scheduling system. Dr. (b) (6), (b) (7)(C) said the book method was used because the scheduling package in VistA was poorly designed and inadequate. Dr. (b) (6), (b) (7)(C) said VistA lacked adequate graphic user interface and the user remained unable to visualize the whole day's schedule at one time. Dr. (b) (6), (b) (7)(C) acknowledged on rare occasions, because the information did not get transferred from the paper log to VistA, a patient showed up that was not expected. Dr. (b) (6), (b) (7)(C) said, "Whenever possible, we tried to accommodate the patient and go ahead and keep the appointment."

In a November 29, 2013, email, Subject: Appointment books, Dr. (b) (6), (b) (7)(C) said: "As many of you already know, VA policy prohibits the use of 'paper' logbooks (including appointment books) in our facilities. For reasons I cannot explain, this rule has not been enforced within the Dental Service in the past, but the hospital leadership has made it clear to me that we must comply ... The VA doesn't currently have a standard electronic scheduling system for Dental Service, so we are left to our own creative devices to come up with something. I took an idea from one of the other Services Chiefs and ran it by the facility Privacy Officer, (b) (6), (b) (7)(C), to see if it would be acceptable ... All past appointments maintained in paper books must be shredded."

Dr. (b) (6) told us that after the scandal related to "logs of patients" in other VA facilities throughout the country, the VAMC was mandated to get rid of the government issued logbooks and start using Sharepoint as VAMC's electronic scheduling system. She said they "completely eliminated pen and paper and everything was put in directly into the computer" and the logbooks were given to Dr. (b) (6), (b) (7)(C). She also said that the logbooks were "shredded and destroyed" and that "there [was] no manipulation of patient information." We interviewed 11 individuals that worked with Dr. (b) (6), (b) (7)(C), and none of them provided any testimony or evidence to substantiate the false documentation allegation.

Conflict of Interest

Standards of Ethical Conduct for Employees of the Executive Branch states that an employee shall not engage in outside employment or any other outside activity that conflicts with their official duties. 5 CFR § 2635.802.

“Employees shall not engage in outside employment or activities, including seeking or negotiating for employment, that conflict with official Government duties and responsibilities. . . . Employees shall endeavor to avoid any actions creating the appearance that they are violating the law or the ethical standards set forth in this part.” 5 CFR § 2635.101(b)(10) and (14).

UAB’s faculty and staff website reflected that Dr. (b) (6), (b) (7)(C) served as an Assistant Professor, Oral & Maxillofacial Surgery. UAB employment records reflected that Dr. (b) (6), (b) (7)(C) started as an Adjunct Assistant Professor on (b) (6), (b) (7)(C), with an annual salary of \$(b) (6), (b) (7)(C). The base salary represented 10% effort or one half Friday per week. Effective (b) (6), (b) (7)(C), Dr. (b) (6), (b) (7)(C)’s UAB salary increased to \$(b) (6), (b) (7)(C) and on (b) (6), (b) (7)(C), her employment status changed from part-time to irregular/temporary.

Dr. (b) (6), (b) (7)(C) said she started employment with UAB in the (b) (6), (b) (7)(C), and she identified her tour of duty as Friday from 1-4:00pm. Dr. (b) (6), (b) (7)(C), Professor and Chairman, Department of Oral & Maxillofacial Surgery, UAB, School of Dentistry, stated that since Dr. (b) (6), (b) (7)(C)’s appointment with VA, she served as an (b) (6), (b) (7)(C) with the UAB Health Service Foundation. Dr. (b) (6), (b) (7)(C) stated that Dr. (b) (6), (b) (7)(C) performed her duties on Friday afternoons (1-5:00pm) and was assigned to the UAB Health Clinic in Hoover, AL. Dr. (b) (6), (b) (7)(C) said he had no evidence that Dr. (b) (6), (b) (7)(C)’s UAB duties interfered with her VA duties.

Dr. (b) (6), (b) (7)(C) said he served as the VAMC Chief of Dental Service from October 2006 to November 2012. Dr. (b) (6), (b) (7)(C) recalled in 2011 or 2012, Dr. (b) (6), (b) (7)(C) treated a patient at a pediatric hospital while on VA time. Dr. (b) (6), (b) (7)(C) said that he remembered a case when a pediatric patient suffered from an injured jaw, but he was unable to remember if this particular case was the same one that Dr. (b) (6), (b) (7)(C) worked while on VA time. He said that he documented the event and directed her to cease and desist, but he was unable to produce any supporting documentation. Dr. (b) (6), (b) (7)(C) said based on his knowledge, Dr. (b) (6), (b) (7)(C) complied with his request. He recalled a couple of individuals in the service who alleged to the contrary, but those individuals could not produce any supporting documentation. Dr. (b) (6), (b) (7)(C) told us that he learned from Dr. (b) (6), (b) (7)(C) that Dr. (b) (6), (b) (7)(C) .

Dr. (b) (6), (b) (7)(C) said that he heard similar “rumors” of such activity, and asked Dr. (b) (6), (b) (7)(C) if she (b) (6), (b) (7)(C), and she assured him that she did not. (b) (6), (b) (7)(C)

In regard to an allegation that she treated patients at the Children of Alabama medical center (CA) on VA time, Dr. (b) (6), (b) (7)(C) acknowledged that she treated two patients at CA; however, the first instance occurred while on annual leave, and the second instance

occurred after her VA tour of duty ended. The CA website reflected that it provided specialized medical care for ill and injured children. CA stood as a private, not-for-profit medical center that served as the primary site of UAB pediatric medicine, surgery, psychiatry, research and residency programs. CA employment records did not have records of Dr. (b) (6).

As a possible contributing factor toward the CA allegation, an April 2012 article, titled: "UAB, Rotary Club team up to help Haitian boy smile again," reflected that Dr. (b) (6) and a team of medical missionaries from UAB met the boy when they visited the island after 2010's earthquake. The article reflected that during that visit, the UAB team learned that the boy suffered from an injured jaw. After meeting the team of doctors in Haiti, the boy visited Birmingham in 2012, and the team performed corrective surgery on the boy's jaw at CA. (b) (6), (b) (7)(C)

(b) (6) We interviewed 6 additional individuals that worked with Dr. (b) (6), and none of them provided any testimony or evidence to substantiate the conflict of interest allegation.

Quality of Care

VA policy states the public interest requires the maintenance of high standards of employee integrity, conduct, effectiveness, and service to the public and that when such standards are not met, it is essential that prompt and just corrective action be taken. VA policy is to maintain standards of conduct and efficiency that will promote the best interests of the service. VA Handbook 5021/3, Part I, Chapter 1, Paragraph 3(a) (June 1, 2005).

The allegation regarding quality of care failed to identify a patient and/or date. We utilized the Patient Advocate Tracking System (PATs) to attempt to narrow the scope of possibilities. PATs serves as a web-based system used to document, track, and report patient related issues. We reviewed PATs reports for the date range of January 2012 to March 2015, and the records failed to substantiate the allegation. Due to archival limitations, PATs data prior to January 2012 were not available.

Ms. (b) (6), (b) (7)(C) told us that to her knowledge, Dr. (b) (6) never used animal bone in a medical procedure after the patient declined due to religious beliefs. However, she told us that through hearsay, she "believed" that she heard Dr. (b) (6) used a specific type of bone during a medical procedure, after the patient declined due to religious beliefs. That hearsay could not be corroborated. Ms. (b) (6), (b) (7)(C), Dental Assistant, said that in 2012, a Jehovah's Witness patient required a bone graft. She recalled Dr. (b) (6) performed the procedure and utilized "synthetic bone." Ms. (b) (6), (b) (7)(C) stated that the patient seemed satisfied with the procedure.

Dr. (b) (6) told us that she recalled a case -- she believed occurred in 2011 -- in which a Jehovah's Witness patient required a bone graft. After discussions with the patient, Dr. (b) (6) said that because of the patient's religious beliefs, the patient could not accept a human blood product, but was allowed to accept animal bone, cow or bovine. She told

us that the patient consented via an electronic consent form that if bone product had to be used, he would absolutely not accept a human product. She said that her first preference remained to give the patient a synthetic, man-made bone substitute, and her second preference remained cow bone. She said after the procedure, she spoke with the patient, and the patient seemed satisfied. Dr. (b) (6) acknowledged that she provided a “synthetic” bone graft to the patient and that the procedure was performed with the full knowledge of the patient. We interviewed eight additional individuals that worked with Dr. (b) (6), and none of them provided any testimony or evidence to substantiate the animal bone allegation.

Conclusion

We did not substantiate the allegation that Dr. (b) (6) engaged in time and attendance abuse. It was alleged that “residents” complained about Dr. (b) (6)’s lateness, but Dr. (b) (6) explained that until a resident got adjusted to the clinic, an individual could experience a sense of frustration. We learned that if Dr. (b) (6) stopped in the middle of a procedure, it was because she could not complete the procedure safely; therefore, she staged or shortened the procedure for medical reasons, not to avoid overtime.

We found no evidence that Dr. (b) (6) engaged in false documentation by manipulating the VAMC logbooks. We learned that there was consensus that a manual method had been utilized. We discovered that as recent as 2015, the use of a manual tracking system continued to be used, but such a practice has since been discontinued and replaced with an electronic SharePoint system.

In regard to conflict of interest, we found no evidence to substantiate this allegation. Dr. (b) (6)’s non-VA employment duties occurred during her day off and did not interfere with her VA duties.

Dr. (b) (6) acknowledged that she provided a “synthetic” bone graft to a Jehovah’s Witness patient; however, the procedure was performed with the full knowledge of the patient. Moreover, we found no evidence of wrongdoing and/or patient complaint(s) to substantiate the allegation. We are therefore closing this investigation with this memorandum.



JEFFREY G. HUGHES
Acting Assistant Inspector General
for Investigations

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