DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Clinical and Administrative Concerns Related to the Podiatry Department at the Lexington VA Medical Center Kentucky

HEALTHCARE INSPECTION | REPORT #17-05440-167 | May 9, 2018

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Executive Summary

At the request of Congressman Andy Barr, the VA Office of Inspector General (OIG) conducted a rapid response healthcare inspection to evaluate clinical and administrative concerns involving a specific podiatrist at the Lexington Veterans Affairs Medical Center (Facility), Kentucky. Two complainants alleged that Podiatrist A

- Did not perform adequate examinations or provide comprehensive care,
- Misrepresented some patients' clinical status in the electronic health record (EHR),
- "Disappeared" from clinic and did not see patients timely, and
- Called out on sick leave the day before clinic, inconveniencing patients and staff.

The complainants further reported that managers ignored the issues instead of fixing the problems. An allegation that managers retaliated against employees who complained was beyond the scope of this report.

The OIG did not substantiate that Podiatrist A performed inadequate podiatry examinations and did not provide comprehensive care. OIG staff reviewed the documentation associated with more than 130 clinic encounters and found that Podiatrist A's documentation was consistent with and generally met Veterans Health Administration (VHA) criteria. OIG staff did not find evidence of poor or inadequate care. Further, OIG staff reviewed Podiatrist A's privileging data and did not identify concerning issues. OIG staff also noted that Podiatrist A has been consistently re-privileged without restriction.

The OIG could not substantiate that Podiatrist A misrepresented some patients' clinical statuses by documenting inaccurately in the EHR. Direct observation at the time of the encounter would be the only definitive way to determine whether a provider is misrepresenting patients' presenting conditions.

The OIG could not substantiate that Podiatrist A "disappears" from the clinic and does not see patients timely. The Chief of Surgery told the OIG that a tardiness concern was previously addressed, and none of the individuals OIG staff interviewed mentioned recent concerns about Podiatrist A's attendance. OIG staff conducted unannounced observations over a two-day period in October 2017 and found that Podiatrist A was in the clinic and saw patients within the scheduled and allotted time frames.

The OIG could not substantiate the complainant's allegation that Podiatrist A's "last-minute" sick leave notification was intentional, which unnecessarily inconvenienced other staff and

patients. The need to use sick leave is often unanticipated, and therefore, clinics should have processes in place to manage these occurrences in a manner that minimizes the inconvenience to patients and staff. On three occasions during a six-month period in 2017, clinics were canceled the day before or day of the clinic due to Podiatrist A's apparent illness or injury. A majority of the 27 patients affected by the cancellations were seen the same day or were rescheduled within two weeks of the date of the clinic cancellation per clinic practice. The patients who were not seen in Podiatry Clinic subsequent to the clinic cancellation either declined the appointment or their condition resolved and a follow-up was no longer needed.

The OIG did not substantiate that leaders ignored the issues rather than fix the problems. Leaders and managers conducted internal reviews and took actions when indicated. Through interviews and document reviews, OIG staff learned of unprofessional conduct and significant discord among Podiatry Department staff. Facility leaders have been aware of the Podiatry Department dysfunction dating back to at least 2014 and acknowledged that the problems have been difficult to resolve. The OIG determined that the culture of mistrust within the Podiatry Department had eroded professionalism and has the potential to place patients at risk for adverse outcomes.

The OIG recommended that the Facility Director develop a clear action plan to resolve the Podiatry Department work environment issues and monitor compliance to ensure patient safety.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the OIG findings and recommendation and provided an acceptable improvement plan. See Appendixes A and B, pages 10–12, for the full text of the comments. The OIG will follow up on the planned action until it is completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

Contents

Abbreviations

ED	Emergency Department
EHR	electronic health record
FY	fiscal year
NCOD	National Center for Organizational Development
PAVE	Prevention of Amputation in Veterans Everywhere
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

Purpose

At the request of Congressman Andy Barr, the VA Office of Inspector General (OIG) conducted a rapid response healthcare inspection to evaluate quality of care and administrative concerns involving a specific podiatrist at the Lexington Veterans Affairs Medical Center (Facility), Kentucky. The purpose of the inspection was to assess the merits of the complaints and determine if the Facility responded appropriately to the quality of care concerns.

Background

Facility Profile

The Facility is a general medicine and surgery facility comprised of two divisions—Leestown and Cooper Drive—with community based outpatient clinics located in Berea, Hazard, Morehead, and Somerset, Kentucky. The Facility operates 203 beds, including 112 inpatient beds, 30 domiciliary beds, and 61 community living center beds, and served over 37,000 veterans in fiscal year (FY) 2016. The Facility is part of Veterans Integrated Service Network (VISN) 9.

Podiatry

Podiatrists treat problems involving the skin, muscles, ligaments, nerves, and bones of the foot and ankle.[1] The Prevention of Amputation in Veterans Everywhere (PAVE) Program is designed to meet the needs of patients at risk[2] for limb amputation and prevent a second amputation of those that have already suffered an amputation. Directive 1410[3] provides recommendations on the frequency for performing the Brief Foot Check, components of the foot exam based on the assigned risk levels, suggested referrals, and required patient education. Veterans Health Administration (VHA) Handbook 1122.01[4] establishes the requirements for delivery of podiatry

[1] Mayo Clinic Definition of Podiatry Services, accessed November 28, 2017, https://mayoclinichealthsystem.org/locations/austin/services-and-treatments/podiatry.

[2] VHA defines patients at risk as those with diabetes, end stage renal disease, peripheral vascular disease, neuropathy, who are susceptible to develop foot ulcers.

[3] VHA Directive 1410, *Prevention of Amputation in Veterans Everywhere (PAVE) Program*, March 31, 2017.

[4] VHA Handbook 1122.01, *Podiatric Medical and Surgical Services for Veterans Health Administration Medical Facilities,* November 25, 2009. This Handbook was scheduled for recertification on or before the last working day of November 2014 and has not yet been updated.

care in the ambulatory setting (clinic). Required documentation elements include a history and physical examination, diagnostic assessment and treatment plan, and documentation of the type of service or treatment provided.

The Facility's Podiatry Department is organizationally aligned under Surgery Service. At the time of the review, the Podiatry Department consisted of two full-time and two fee-for-service podiatrists, two surgical technicians, and two medical support assistants. A Podiatry Department nurse case manager who had been coordinating patient care moved to a different position in June 2017.

Allegations

On July 20 and 25, 2017, two complainants sent separate letters to Congressman Andy Barr alleging that a podiatrist (Podiatrist A) delivered poor podiatry care at the Facility. In support of the allegations, one of the complainants provided names and identifying information for two patients who received care in 2017.

The complainants also alleged that Podiatrist A

- Did not perform adequate examinations or provide comprehensive care,
- Misrepresented some patients' clinical status in the electronic health record (EHR),
- "Disappeared" from clinic and did not see patients timely, and
- Called out on sick leave the day before clinic, inconveniencing patients and staff.[5]

The complainants further reported that managers ignored the issues instead of fixing the problems. An allegation that managers retaliated against employees who complained was beyond the scope of this report.

Scope and Methodology

The OIG initiated the review on October 16, 2017 and conducted a site visit October 24–25, 2017. The data review included selected documents spanning FY 2013 through October 25, 2017.

Prior to the site visit, OIG staff interviewed the complainants by telephone. Additionally, OIG staff interviewed the Facility's director, Chief of Staff, Chief of Surgery, Podiatrists A, B, C, and D, and the Chief Nurse of Surgery, as well as the Outpatient Surgery Clinic Nurse Manager, Nurse Case Manager of the Podiatry Department, the patient advocate, and other employees of

[5] The complainants implied that Podiatrist A intentionally notified the clinic "at the last minute" about being on sick leave, resulting in an inconvenience to patients and staff.

the Podiatry Department with knowledge of the issues. OIG staff conducted an unannounced observation of Podiatrist A's clinics to evaluate the timing of Podiatrist A's entries and exits from the examination rooms.

OIG staff reviewed relevant Facility policies and VHA directives and handbooks. Additionally, OIG staff reviewed Facility quality and internal management reports, podiatry providers' privileging data, PAVE and Podiatry Clinic cancellation data, patient advocate reports, and other documents relevant to these allegations. OIG staff performed EHR reviews of the two patients identified in the original complaint. OIG staff also reviewed EHR documentation associated with 128 clinic encounters. The selected encounters involved patients with specified diagnoses who were seen by Podiatrist A during a six-month period in 2017. Additionally, the OIG reviewed the EHRs of nine patients with reported quality of care issues that were identified through interviews or document reviews.

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).

The OIG substantiates allegations when the facts and findings support that the alleged events or actions took place. The OIG does not substantiate allegations when the facts show the allegations are unfounded. The OIG cannot substantiate allegations when there is no conclusive evidence to either sustain or refute the allegation.

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

Issue 1. Quality of Podiatry Care

Patients 1 and 2

The OIG did not substantiate that Podiatrist A provided poor care to the two patients specifically named by one of the complainants.

Patient 1 had a history of diabetes and neuropathy and was at high risk for foot problems. The complainant alleged that during a clinic appointment in spring 2017, the patient had "…multiple blisters beneath the sock. [Patient 1's] right sock had blood from the patient scratching [the] upper medial shin and some fluid filled blisters on [the] lower leg." The complainant further alleged that Podiatrist A was told of these findings and replied, "Everything looks fine."

Podiatrist A documented the patient had healed leg wounds, "significant edema," and complaints of painful toenails. Podiatrist A also documented the technician debrided the patient's toenails. Podiatrist A did not document observing bleeding or blisters on the patient's leg. Patient 1 has not returned to the Podiatry Clinic since the 2017 visit but has been seen in numerous other clinics since that time. Based on a review of patient 1's EHR and related documents, the OIG did not identify care concerns associated with the 2017 visit.

Patient 2 had a history of diabetes and recurrent foot ulcers and had been receiving podiatry care from Podiatrist A for the past five years. The complainant alleged that in mid-2017, patient 2's foot condition indicated a need for inpatient treatment but instead Podiatrist A sent the patient home.

Patient 2 had a morning appointment in the PAVE Clinic. Podiatrist A documented that patient 2 had been off antibiotics for approximately one week and the left and right toe ulcers were healing and without signs of infection. Podiatrist A ordered lab work to evaluate resolution of a previous infection and was waiting for the completion of a previously ordered imaging study (that was scheduled to take place two days later) to evaluate for bone involvement. Patient 2 was given instructions to go to the Emergency Department (ED) if signs or symptoms of infection developed and was cleared to go home. Lab results received later that day, however, indicated the possibility of an infection and the patient was asked to return to the Podiatry Clinic for cultures of the toes. Patient 2 returned to the Podiatry Clinic in the mid-afternoon, was noted to be sweaty and pale looking, and was admitted to an inpatient unit and had an amputation of one toe two days later.

Based on a review of patient 2's EHR and related documents, the OIG found no evidence that Podiatrist A's decision to send the patient home (rather than wait for the lab results) was improper. The patient's condition appeared stable at the time Podiatrist A made a clinical judgment to send the patient home, and Podiatrist A provided clear instructions to go to the ED if

needed. The OIG also found no evidence that Podiatrist A provided poor care to this patient. EHR documentation reflected appropriate evaluation and treatment planning during the mid-2017 visit, and while the toe amputation was unfortunate, amputations are nonetheless an ongoing possibility in this high-risk population.

Overall Quality and Comprehensiveness

The OIG did not substantiate that Podiatrist A did not perform adequate podiatry examinations or provide comprehensive care.

Using the criteria outlined in VHA Directive 1410 (relative to the brief foot check and high risk foot examination), along with the documentation requirements identified in VHA Handbook 1122.01, the OIG performed an EHR review of Podiatrist A's encounters for selected patients[6] for a six-month time period in 2017. OIG staff reviewed 128 encounters—64 for patients with a single visit and 22 for patients with multiple encounters.[7] In each case, OIG staff found Podiatrist A's documentation to be consistent with VHA's high-risk foot exam criteria and included those aspects of care required to be documented as outlined in Handbook 1122.01. OIG staff also determined that for patients with multiple Podiatry Clinic appointment encounters, Podiatrist A documented changes in the patients' clinical statuses from one appointment to the next and when appropriate, modified the plans of treatment to reflect those changes. The OIG did not find evidence of inadequate examinations or lack of comprehensive care.

Through interviews or document review, OIG staff learned about an additional nine patients who may have received poor care from Podiatrist A or a related contact with the Patient Advocate. The OIG reviewed the nine EHRs but did not find evidence of poor or inadequate care in these cases.

To determine whether Facility leaders evaluated Podiatrist A's competency to perform podiatry examinations and procedures, OIG staff reviewed Ongoing Professional Practice Evaluation (OPPE)[8] data from October 2013 through March 2017. The OIG did not identify concerning issues and noted that Podiatrist A has been consistently re-privileged without restriction.

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[6] The selected population included patients with diagnoses of diabetes mellitus, peripheral neuropathy, and/or peripheral vascular disease, *and* one or more of the following within 30 days of the clinic encounter with Podiatrist A: new diagnosis of lower extremity ulcer or infection; unscheduled return to Podiatry Clinic; hospital admission; ED visit; surgery; or death.

[7] Patient B, who had five encounters during the review period, was included in this total.

[8] VHA Handbook 1100.19, *Credentialing and Privileging,* October 15, 2012. This Handbook was scheduled for recertification on or before the last day of October 2017 and has not yet been recertified. The on-going monitoring of privileged practitioners, as occurs through OPPE, is essential to confirm the quality of care delivered. This allows the medical facility to identify professional practice trends that impact quality of care and patient safety. The re-privileging process needs to include consideration of such factors as the number of procedures performed or major diagnoses treated, rates of complications compared with those of others doing similar procedures, and adverse results indicating patterns or trends in a practitioner's clinical practice.

Accuracy of Documentation

The OIG could not substantiate that Podiatrist A misrepresented some patients' clinical statuses by documenting inaccurately in the EHR. Direct observation of Podiatrist A's examination and documentation at the time of the encounter would be the only definitive way to fairly and credibly determine whether a provider is misrepresenting patients' presenting conditions.

Issue 2. Clinic Management

The OIG could not substantiate that Podiatrist A "disappears" from the clinic and does not see patients timely. The complainant did not include specific dates and times that Podiatrist A was not in the clinic as scheduled; therefore, the OIG could not reasonably assess Podiatrist A's timeliness and ongoing presence in the clinic on dates in the past.

The OIG found, however, that the Facility conducted a review focusing on several dates between October 2016 and April 2017 when Podiatrist A was reportedly not present in the clinic. Further, the Chief of Surgery told the OIG that he addressed a tardiness issue with Podiatrist A and that the condition improved. None of the individuals interviewed mentioned recent concerns about Podiatrist A's attendance. The OIG conducted unannounced observations on October 24–25, 2017 and found that Podiatrist A was in the clinic and saw patients within the scheduled and allotted time frames.

The OIG could not substantiate the complainant's implication that Podiatrist A's "last-minute" sick leave notification was intentional, which unnecessarily inconvenienced other staff and patients. The majority of the 27 patients were able to be seen the same day or were rescheduled within two weeks of the date of the clinic cancellation.

The need to use sick leave is often unanticipated, and therefore, clinics should have processes in place to manage these occurrences in a manner that minimizes the inconvenience to patients and staff. When providers call in sick, clinic practice is to notify the patient before the appointment time so that the patient does not make an avoidable trip. If the patient does arrive at a canceled clinic, the patient has the choice of an appointment that day by a different provider or rescheduling the appointment. Reportedly, patients who request to have their appointments rescheduled are seen within two weeks of the canceled appointment.

The OIG confirmed three occasions during a six-month time period in 2017, when clinic appointments were canceled the day before or day of the clinic due to Podiatrist A's apparent illness or injury. A majority of the 27 patients affected by the cancellations were seen the same day or were rescheduled within two weeks of the date of the clinic cancellation per clinic practice. The patients who were not seen in Podiatry Clinic subsequent to the clinic cancellation either declined the appointment or their condition resolved and a follow-up was no longer needed.

Issue 3. Leadership Responsiveness to Concerns

The OIG did not substantiate that leaders ignored the issues rather than fix the problems. The OIG determined that leaders and managers conducted appropriate internal reviews in response to podiatry-related complaints and took actions when indicated. Of note, the OIG found that some Podiatry Department staff did not consistently endeavor to recognize and include Podiatrist A as a team member. Through interviews and document reviews, the OIG learned of unprofessional conduct and significant discord among Podiatry Department staff that impaired the team's ability to provide veterans with quality medical care.

Podiatrist A told the OIG that none of the Podiatry Department staff brought patient care or documentation concerns to his/her attention. Podiatrist A attributed this lack of communication and collaboration to a "push back" from staff after changes to Department operations and processes were introduced several years ago.

Facility leaders have been aware of the Podiatry Department dysfunction dating back to at least 2014 and acknowledged that the problems have been difficult to resolve. The OIG determined the culture of mistrust within the Podiatry Department has eroded professionalism and has the potential to place patients at risk for adverse outcomes.

Conclusion

The OIG did not substantiate that Podiatrist A performed inadequate podiatry examinations and did not provide comprehensive care. OIG staff reviewed EHR documentation associated with more than 130 clinic encounters and found that Podiatrist A's documentation was consistent with and generally met all VHA criteria. OIG staff did not find evidence of poor or inadequate care. OIG staff reviewed Podiatrist A's OPPE and did not identify concerning issues. The OIG noted that Podiatrist A has been consistently re-privileged without restriction.

The OIG could not substantiate that Podiatrist A misrepresented some patients' clinical statuses by documenting inaccurately in the EHR. Direct observation at the time of the encounter would be the only definitive way to determine whether a provider is misrepresenting patients' presenting conditions.

The OIG could not substantiate that Podiatrist A disappeared from the clinic and did not see patients timely. The Chief of Surgery previously addressed a tardiness concern, and none of the individuals interviewed mentioned recent concerns about Podiatrist A's attendance. OIG staff conducted unannounced observations over a two-day period in October 2017 and found that Podiatrist A was in the clinic and saw patients within the scheduled and allotted time frames.

The OIG could not substantiate the complainant's allegation that Podiatrist A's "last-minute" sick leave notification was intentional, which unnecessarily inconvenienced other staff and patients. The need to use sick leave is often unanticipated, and therefore, clinics should have processes in place to manage these occurrences in a manner that minimizes the inconvenience to patients and staff. OIG staff confirmed three occasions during a six-month time period in 2017 when clinics were canceled the day before or day of the clinic due to Podiatrist A's apparent illness or injury. A majority of the 27 patients affected by the cancellations were seen the same day or were rescheduled within two weeks of the date of the clinic cancellation per clinic practice. The patients who were not seen in Podiatry Clinic subsequent to the clinic cancellation either declined the appointment or their condition resolved and a follow-up was no longer needed.

The OIG did not substantiate that leaders ignored the issues rather than fix the problems. Leaders and managers conducted appropriate internal reviews and took actions when indicated. Through interviews and document reviews, the OIG learned of unprofessional conduct and significant discord among Podiatry Department staff. Facility leaders have been aware of the Podiatry Department dysfunction dating back to at least 2014 and acknowledged that the problems have been difficult to resolve. The OIG determined that the ongoing intra-departmental conflict has eroded professionalism and has the potential to place patients at risk for adverse outcomes.

The OIG made one recommendation.

Recommendation 1

The Lexington VA Medical Center Director develops a clear action plan to resolve the Podiatry Department work environment issues and monitors compliance to ensure patient safety.

Appendix A: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: April 2, 2018

From: Director, VA MidSouth Healthcare Network (10N9)

Subj: Healthcare Inspection—Clinical and Administrative Concerns Related to the Podiatry Department, Lexington VA Medical Center, Kentucky

To: Director, Rapid Response, Office of Healthcare Inspections (54RR)

Director, Management Review Service (VHA 10E1D MRS Action)

1. I have reviewed and concur with the findings and recommendations in the OIG report entitled, V09-18-16-Draft Report-Clinical and Administrative Concerns Related to the Podiatry Department, Lexington VA Medical Center, Lexington, KY.
2. If you have questions or require additional information, please do not hesitate to contact Angela Malik, VISN Quality Manager at (615-695-2143).

(Original signed by:)

Cynthia Breyfogle, FACHE

Appendix B: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: March 26, 2018

From: Director, Lexington VA Medical Center (596/00)

Subj: Healthcare Inspection— Clinical and Administrative Concerns Related to the Podiatry Department, Lexington VA Medical Center, Kentucky

To: Director, VA MidSouth Healthcare Network (10N9)

1. Thank you for the opportunity to review and respond to the Clinical Administrative Concerns. I concur with the finding and recommendation.
2. Our response to the report recommendation is attached. We are actively working on improvements. We appreciate the perspective from the Office of Inspector General evaluation and will take this opportunity to strengthen and improve our medical center processes.

(Original signed by:)

James E. Belmont, FACHE, CAAMA

Comments to OIG's Report

Recommendation 1

The Lexington VA Medical Center Director develops a clear action plan to resolve the Podiatry Department work environment issues and monitors compliance to ensure patient safety.

Concur.

Target date for completion: 11/01/2018

Director Comments

An assessment of team functioning in Podiatry was completed by National Center for Organizational Development (NCOD) on January 8-26, 2018. Podiatry staff meeting is scheduled on April 28, 2018 to discuss results and engage staff in improving morale. Six months following staff based training a repeat team assessment will be given to allow time for moral changes. Conflict resolution management will be arranged with the two full-time podiatrists.

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Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Eileen Keenan, RN, MSN, Team Leader Monika Spinks, RN, BSN, Team Leader Gail Bozzelli, RN Victoria Coates, LICSW, MBA Dannette Johnson, MD Judy Montano, MS Larry Selzler, MSPT Mary Taylor, RN, BSN Toni Woodard, BS
Other Contributors	Nicholas Ditondo Kathy Gudgell, RN, JD Eli Lawson Larry Ross, Jr.

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