DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Inadequate Resident Supervision and Documentation of an Ophthalmology Procedure at the Oklahoma City VA Health Care System in Oklahoma

HEALTHCARE INSPECTION | REPORT #20-03886-141 | MAY 18, 2021

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Executive Summary

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

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess three separate sets of allegations related to ophthalmology resident physician (resident) supervision and quality of care provided by an attending ophthalmologist (subject ophthalmologist) at the Oklahoma City VA Health Care System (facility) in Oklahoma.[1]

The OIG received specific allegations related to the subject ophthalmologist:

- Was unable to be reached but documented being present during the care of a patient with sudden vision loss
- Violates Veterans Health Administration (VHA) Handbook 1400.01 by not consistently being present to supervise residents[2]
- Falsely states in the electronic health record (EHR) attendance in clinic and assisting with the care of patients
- Does not provide proper oversight for intravitreal injections and laser procedures
- Fails to provide and document proper patient care by not following VHA Handbook 1121.01 and the American Academy of Ophthalmology preferred practice guidelines (AAO guidelines)[3]

Summary of Events

In summer 2019, a patient examined by a post graduate year (PGY) 2 resident in the clinic was found to have worsening vision with increased perifoveal intraretinal fluid and central exudate in the left eye. The PGY2 resident obtained patient consent for an anti-vascular endothelial growth factor (VEGF) injection and completed the procedure.[4] The procedure was complicated by an immediate post-injection loss of vision and elevated intraocular pressure. The PGY2 resident consulted the PGY3 resident in the clinic for assistance. The PGY3 resident performed an anterior chamber tap (AC tap) and ocular massage with some improvement in vision. However, a few minutes later the patient reported continued worsening of vision. The residents were unable

[1] The OIG team noted several terms used for staff and attending ophthalmologist. For the purposes of this report, the OIG uses the term attending.

[2] VHA Handbook 1400.01, *Resident Supervision,* December 19, 2012.

[3] VHA Handbook 1121.01, *VHA Eye Care*, March 10, 2011. American Academy of Ophthalmology, Summary Benchmarks for Preferred Practice Pattern® Guidelines, October 2016, accessed November 9, 2020, https://www.aao.org/summary-benchmark-detail/summary-benchmarks-full-set-2019.

[4] Residents can independently perform an injection after being trained and initially supervised.

to contact the subject ophthalmologist and the patient was "immediately examined" by an attending ophthalmologist who repeated the AC tap with good response.

Healthcare Inspection Results

The OIG substantiated that the subject ophthalmologist failed to provide adequate resident supervision and entered inaccurate documentation related to supervision for a single patient case. The residents were unable to reach the subject ophthalmologist when the patient experienced continued decrease in vision and the subject ophthalmologist did not arrange a hand-off for attending coverage when away from the clinic. A note in the patient's EHR shows that the subject ophthalmologist entered a templated addendum to the note, as was the subject ophthalmologist's routine practice when documenting resident supervision. This addendum inaccurately documented that the subject ophthalmologist directly participated in and was present during the care of the patient, which was not the case. Upon review of the addendum with the OIG, the subject ophthalmologist acknowledged the addendum was incorrect due to failure to read and edit the EHR note before signing it.

Aside from the single patient case, the OIG did not identify any other failures to supervise residents or inaccurate documentation of resident supervision by the subject ophthalmologist. Upon inquiry by the OIG, residents, attending ophthalmologists, and other staff shared general concerns about being able to reach the subject ophthalmologist when assigned to provide resident supervision in the clinic. However, no other specific cases were identified where the subject ophthalmologist was not available when needed. Prior to the OIG inspection, the facility conducted routine reviews of resident supervision as well as a review specific to the subject ophthalmologist. These reviews identified documentation of resident supervision as expected. The OIG agreed the reviews provided evidence of the subject ophthalmologist's presence in the facility and documentation of resident supervision in the EHR. Additionally, during interviews, facility leaders stated the subject ophthalmologist was no longer providing resident supervision due to a request in change of duties which included no longer supervising residents.

The subject ophthalmologist, aside from the single patient case, provided and documented proper patient care following VHA Handbook 1121.01 and AAO guidelines.[5] A review of 20 patients performed by an external ophthalmologist and the OIG determined the subject ophthalmologist provided acceptable quality of care and appropriate documentation. The complainant reported having no continued concerns about the subject ophthalmologist's quality of care and documentation.

[5] VHA Handbook 1121.01. American Academy of Ophthalmology, *Summary Benchmarks for Preferred Practice Pattern® Guidelines*, October 2016, accessed November 9, 2020, https://www.aao.org/summary-benchmark-detail/summary-benchmarks-full-set-2019.

The OIG made three recommendations to the Facility Director related to documentation of resident supervision and a hand-off process for covering attending ophthalmologists.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations and provided acceptable actions plans (see appendixes A and B for the Directors' comments). Based on information provided, the OIG considers recommendation 1 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are complete.

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

Contents

Abbreviations

AAO	American Academy of Ophthalmology
AC	anterior chamber
EHR	electronic health record
OIG	Office of Inspector General
PGY	post graduate year
VEGF	vascular endothelial growth factor
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations related to ophthalmology resident physician (resident) supervision and quality of care provided by an attending ophthalmologist (subject ophthalmologist) at the Oklahoma City VA Health Care System (facility) in Oklahoma.[1]

Background

The facility, part of Veterans Integrated Service Network (VISN) 19, provides comprehensive healthcare in the areas of emergency, acute, primary, specialty, and surgical care including ophthalmology. The facility is designated as Level 1b, high complexity, and has 192 beds.[2] From October 1, 2019, through September 30, 2020, the facility served 63,470 patients.

Facility Ophthalmology Residency Program

The facility participates in an ophthalmology residency program that is managed by the Dean McGee Eye Institute at the University of Oklahoma College of Medicine. The ophthalmology residency program is three years and the facility allows residents to provide care to VA patients during clinical rotations of the second, third, and fourth post graduate years (PGY2, PGY3, PGY4). Oversight of PGY2, PGY3, and PGY4 residents by an attending ophthalmologist is required. Based on a resident's strengths and weaknesses, the attending ophthalmologist determines the resident's level of independence while treating patients. Ultimately, the training should enhance the resident's skills while addressing deficits.[3]

Allegations

On January 5 and 22, 2020, the OIG received three separate sets of allegations concerning the subject ophthalmologist. The OIG referred the allegations to facility leaders on March 19, 2020. The OIG received an inadequate facility response on June 11, 2020. In July 2020, the OIG sent two requests to facility leaders for additional information. The OIG found that facility leaders'

[1] The OIG team noted several terms used for staff and attending ophthalmologist. For the purposes of this report, the OIG uses the term attending.

[2] "The Facility Complexity Model classifies VHA facilities at levels 1a, 1b,1c, 2, or 3 with level 1a being the most complex and level 3 being the least complex." A level 1b facility has "medium-high volume, high risk patients, some complex clinical programs, and medium-large sized research and teaching programs." VHA Office of Productivity, Efficiency, & Staffing, "Facility Complexity Level Model Fact Sheet." (This website was accessed on August 27, 2020.)

[3] VHA Handbook 1400.01, *Resident Supervision,* December 19, 2012. This handbook was in effect for the timeframe discussed in this report. The 2012 handbook was rescinded and replaced by VHA Directive 1400.01, *Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents*, November 7, 2019. The handbook and the directive contain the same or similar language concerning resident supervision.

responses to both of these requests were also inadequate. Therefore, the OIG initiated an inspection to review the following allegations related to the subject ophthalmologist's resident supervision and documentation of patient care:

1. Resident Supervision

   - Was unable to be reached but documented being present during the care of a patient with sudden vision loss.
   - Violates Veterans Health Administration (VHA) Handbook 1400.01 by not consistently being present to supervise residents.[4]
   - Falsely states in the electronic health record (EHR) attendance in clinic and assisting with the care of patients.
   - Does not provide proper oversight for intravitreal injections and laser procedures.

2. Documentation of Patient Care

   - Fails to provide and document proper patient care by not following Handbook 1121.01 and the American Academy of Ophthalmology preferred practice guidelines (AAO guidelines).[5]

Scope and Methodology

The OIG initiated the inspection on August 10, 2020, and conducted a virtual site visit October 20–22, 2020.

The OIG team interviewed the Facility Director; Chief of Staff; Chief of Quality, Safety, and Value; Associate Chief of Staff for Education; compliance staff; attending ophthalmologists; facility's Ophthalmology Residency Director; ophthalmology residents; Dean McGee Eye Institute Residency Program Director; and the ophthalmology clinic supervisor. Prior to the virtual site visit, the OIG team interviewed the complainant and two ophthalmologists from another VA medical center.

The OIG reviewed relevant VHA and facility policies related to resident supervision, EHR documentation, and ophthalmology services. In addition, facility reviews, ophthalmology attending schedules, resident supervision audits, Dean McGee Eye Institute residents' graduated levels of responsibility, and peer review committee meeting minutes were examined.

[4] VHA Handbook 1400.01.

[5] VHA Handbook 1121.01, *VHA Eye Care*, March 10, 2011. This handbook was in effect for the timeframe discussed in this report. The 2011 handbook was rescinded and replaced by VHA Directive 1121, *VHA Eye and Vision Care*, October 2, 2019, amended August 18, 2020. The handbook and the directive contain the same or similar language concerning resident supervision. American Academy of Ophthalmology, Summary Benchmarks for Preferred Practice Pattern® Guidelines, October 2016, accessed on November 9, 2020, https://www.aao.org/summary-benchmark-detail/summary-benchmarks-full-set-2019.

The OIG reviewed the subject ophthalmologist's resident supervision and EHR documentation from July 2019 to March 2020.

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 an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

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 1105, 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. Ophthalmology Resident Supervision

VHA policy requires that an attending ophthalmologist be physically present and document the level of supervision provided in outpatient clinics when residents are involved in patient care.[6]

Further, VHA policy allows delegation to other attending ophthalmologists to supervise residents; however, the assigned attending ophthalmologist is responsible for ensuring the residents are informed of such delegation and can readily access an attending ophthalmologist at all times.

In addition, VHA policy requires that documentation by the attending ophthalmologist accurately reflects the level of attending involvement for each individual resident-patient encounter.[7]

Inadequate Resident Supervision for a Single Case

The OIG substantiated that the subject ophthalmologist failed to provide adequate resident supervision and falsified documentation related to supervision for a single patient case. The OIG found the subject ophthalmologist was unable to be reached by the residents and did not arrange for attending coverage during the absence for a single patient case.

Summary of Events

In summer 2019, a patient with a history of non-proliferative diabetic retinopathy, macular edema, and hypertensive retinopathy presented to the ophthalmology clinic for a three-month follow-up eye examination. The patient was last treated with an anti-vascular endothelial growth factor (VEGF) injection in 2015. When examined by the PGY2 resident in the clinic, the patient was found to have worsening vision with increased perifoveal intraretinal fluid and central exudate in the left eye. Due to worsening vision, it was determined the patient should undergo a second anti-VEGF injection. The PGY2 resident obtained patient consent for the procedure and completed the anti-VEGF injection.[8] The procedure was complicated by an immediate post-injection loss of vision and elevated intraocular pressure. The PGY2 resident consulted the PGY3 resident in the clinic for assistance. The PGY3 resident performed an anterior chamber tap (AC tap) and ocular massage with some improvement in vision. However, a few minutes later the patient reported continued worsening of vision with blurring and blackening of central vision. As stated in a note in the EHR, the patient was "immediately examined" by an attending ophthalmologist who repeated the AC tap and removed 2 milliliters of fluid from the eye with

[6] VHA Handbook 1400.01.

[7] VHA Handbook 1400.01.

[8] Residents can independently perform an injection after being trained and initially supervised.

good response. The attending ophthalmologist entered an addendum in the EHR documenting evaluation of the patient and that a second AC tap was performed with gradual return of vision. Additionally, the subject ophthalmologist placed an addendum in the EHR that documented direct participation with and presence during the care of the patient.

OIG Findings

The PGY3 resident told the OIG that after the first AC tap was performed, the residents called the subject ophthalmologist to explain the situation. The subject ophthalmologist stated the intervention was appropriate. Both PGY2 and PGY3 residents told the OIG that when the patient had continued worsening of vision with blurring and blackening of central vision, they were unable to reach the subject ophthalmologist by telephone or text message. After waiting one or two minutes, the PGY3 resident called the attending ophthalmologist for assistance. The attending ophthalmologist told the OIG of being responsible to the operating room; but the surgical case was completed and the attending ophthalmologist was able to go to the ophthalmology clinic to examine the patient and assist the residents.

The subject ophthalmologist told the OIG of not being physically present in the ophthalmology clinic during the care of the patient due to attendance at an emergency peer review meeting. A review of the peer review committee meeting minutes from that day confirmed that the subject ophthalmologist was in attendance at the meeting held during the same time the patient was seen. In addition, the OIG reviewed the ophthalmology attending schedule, which confirmed, the subject ophthalmologist was assigned to supervise residents in the ophthalmology clinic while the attending ophthalmologist was assigned to supervise residents in the operating room.

As supported in VA policy, the Associate Chief of Staff for Education stated that attending ophthalmologists are allowed to step away from the clinic area as long as residents are able to contact them when necessary.[9] The Associate Chief of Staff for Education and attending ophthalmologists told the OIG that there was no formal process for a hand-off to address resident supervision when an attending ophthalmologist is unavailable.

A note in the patient's EHR showed that the subject ophthalmologist entered a templated addendum to the note as was the subject ophthalmologist's routine practice when documenting resident supervision. Upon review of the addendum with the OIG, the subject ophthalmologist said that the addendum was incorrect because of not directly participating in and not being physically present during the care of the patient. Additionally, the subject ophthalmologist stated that the addendum language used was a standard template and acknowledged failure to read and edit the EHR note before signing it. The OIG learned from the Associate Chief of Staff for Education and the facility's Ophthalmology Residency Site Director that attending ophthalmologists are encouraged to write an addendum to the resident's EHR note that

[9] VHA Handbook 1400.01.

accurately documents the level of supervision. The Associate Chief of Staff for Education and the facility's Ophthalmology Residency Site Director confirmed that the addendum language used by the subject ophthalmologist was a standard template and stated that when a template was used, it is expected to be edited to convey the level of supervision provided.

The OIG found evidence that for a single patient case, the subject ophthalmologist failed to adequately provide and document resident supervision. The OIG determined that the residents were unable to reach the subject ophthalmologist when the patient experienced continued decrease in vision. Due to the lack of a formal hand-off process, the subject ophthalmologist did not arrange for a hand-off for attending coverage. The unedited template used by the subject ophthalmologist inaccurately documented who was present when care was provided to the patient.

Alleged Failure to Supervise Residents

Aside from the single patient case above, the OIG did not substantiate that the subject ophthalmologist failed to supervise residents or falsified documentation of resident supervision.

The OIG learned through an interview with the Chief of Quality, Safety, and Value that facility quality management staff reviewed a sample of EHRs monthly for the Surgery Service, which included the ophthalmology clinic. Additionally, the Chief of Quality, Safety, and Value reported no concerns were identified with documentation of resident supervision by ophthalmology attendings.

In December 2019, the facility completed another review after concerns were brought to the attention of compliance staff about inadequate supervision and documentation by the subject ophthalmologist. Compliance staff conducted a review of documentation for clinic visits on dates provided when allegedly the subject ophthalmologist was responsible for supervising residents and was not present in the clinic. The review relied on information available in electronic data from administrative and clinical systems, including the EHR, but lacked testimony from the ophthalmology residents and the subject ophthalmologist. The review concluded that the subject ophthalmologist was present in the facility and supervised residents based on evidence that the subject ophthalmologist logged into the computer and EHR notes by residents and the subject ophthalmologist documenting supervision of residents. Throughout the course of the review, facility leaders identified an opportunity for the subject ophthalmologist to improve communication to the residents and other attendings regarding coverage for resident supervision. Facility leaders recommended the subject ophthalmologist inform staff when going on leave or not going to be present in the clinic, and how to be reached or who the attending in the clinic would be during the absence.

The OIG agreed the compliance staff's review provided evidence of the subject ophthalmologist's presence in the facility and documentation of resident supervision in the EHR. However, the OIG determined that the electronic databases used in the facility review do not

provide the necessary detail to indicate if residents received the supervision they require for a patient encounter or if the subject ophthalmologist's documentation in the EHR was consistent with the supervision provided. A more conclusive review of the subject ophthalmologist's resident supervision and accuracy of documentation would encompass interviews with the subject ophthalmologist, residents involved in the care of each patient, and comparison to what was documented in the EHR.

For a more complete review, the OIG interviewed four residents that rotated one or more times through the ophthalmology clinic. When asked about the subject ophthalmologist's level of supervision, three of the four residents stated the subject ophthalmologist was generally available but there were times the subject ophthalmologist was somewhere else in the facility during times they were caring for patients.[10] The residents could not provide patient names or dates of concern other than the aforementioned patient case.

During interviews with attending ophthalmologists, three of four stated they knew of residents sharing concerns about not being able to reach the subject ophthalmologist when residents were seeing patients in the ophthalmology clinic.[11] However, none of the other ophthalmologists had firsthand knowledge of specific dates or patient names related to those concerns.

Additionally, through interviews, facility leaders stated they were aware of concerns with the subject ophthalmologist's availability to provide resident supervision. Leaders stated that the facility reviewed evidence showing resident supervision for those visits previously identified in the compliance staff's review and no additional concerns were brought forward.

In response to concerns with resident supervision, the Associate Chief of Staff for Education implemented a daily walk-through of the ophthalmology clinic to assess if an attending ophthalmologist was present when residents were seeing patients. Since the initiation of these walk-throughs in July 2020, the Associate Chief of Staff for Education had not identified lapses in supervision for any attending ophthalmologist.

Upon inquiry by the OIG, residents, attending ophthalmologists, and other staff shared general concerns about being able to reach the subject ophthalmologist when assigned to provide resident supervision in the clinic. However, no other specific cases were identified where the subject ophthalmologist was not available when needed. Aside from a single patient case, the OIG did not identify any other failures to supervise residents or falsify documentation by the subject ophthalmologist. Additionally, during interviews, facility leaders stated the subject ophthalmologist is no longer providing resident supervision due to a request in change of duties which included no longer supervising residents.

[10] The one remaining resident said the subject ophthalmologist supervised and was available to the same extent as any other attending.

[11] The one remaining attending ophthalmologist discussed general availability issues; however, did not say anything specifically related to the subject ophthalmologist.

Alleged Inadequate Supervision of Injections and Laser Procedures

The OIG did not substantiate, aside from the single patient case, that the subject ophthalmologist failed to provide oversight of residents performing injections and laser procedures.

VHA policy states that as part of a resident's graduated levels of responsibility, a resident can provide care to patients without supervision based on an attending practitioner's "evaluation of the resident's clinical experience, judgment, knowledge, and technical skill" and the levels of responsibility defined by the year of training and type of clinical activity.[12]

According to the Dean McGee Eye Institute Residency Program Director and the facility Ophthalmology Residency Site Director, residents can perform injections and laser procedures after being trained and initially supervised by attending ophthalmologists.

The letter of agreement between the Dean McGee Eye Institute ophthalmology residency program and the facility indicated that PGY2, PGY3, and PGY4 residents can perform laser procedures and injections, and will learn to identify and manage complications. The job description for a PGY2 indicates that under indirect supervision, residents can perform simple diagnostic and invasive procedures with the expectation that they contact an upper-level resident or attending ophthalmologist when questions arise.

During interviews with the OIG, the Dean McGee Eye Institute Residency Program Director and the facility's Ophthalmology Residency Site Director stated that residents begin performing injections and laser procedures early in their residency program; most within their first month of training. Four of the attending ophthalmologists interviewed described injections as fairly routine procedures that are commonly performed by residents without direct supervision after the residents have initially completed several under supervision. The Dean McGee Eye Institute Residency Program Director noted injections are so common in the outpatient setting that residents frequently graduate completing 1,000. Additionally, the Dean McGee Eye Institute Residency Program Director told the OIG that residents would perform laser procedures independently after initial supervision.

Besides the August 16, 2019, patient case, the OIG did not learn of reports of residents performing injections or laser procedures without an attending available for supervision. Due to the absence of specific cases brought to the attention of the OIG and the routine nature of both procedures, the OIG did not find evidence that the subject ophthalmologist failed to provide oversight of residents who performed injections and laser procedures.

[12] VHA Handbook 1400.01.

2. Alleged Failure to Provide and Document Proper Patient Care

The OIG did not substantiate, aside from the single patient case, that the subject ophthalmologist failed to provide and document proper patient care in patient EHRs by not following Handbook 1121.01 and AAO guidelines.

VHA policy states that the facility will provide eye care services as defined by AAO guidelines.[13] AAO guidelines provide recommendations for care that vary based upon the specific type of disease condition. For example, postoperative follow-up should occur anywhere from one day to two weeks, depending on the patient's diagnosis and the type of procedure.[14]

VHA policy requires that staff practitioners enter clear and concise progress notes in patient EHRs to ensure documentation of treatment and to facilitate continuity of care. These notes should be entered timely and include the purpose of the visit, the patient's complaint, relevant medical history, diagnosis, any treatment provided, and the plan for ongoing care.[15] Prior to an operation or procedure, the practitioner is required to document discussions with a patient regarding the findings of their evaluation, diagnosis, treatment plan, discussion of the risks, benefits, potential complications, and alternatives to the surgery or therapeutic procedure.

The Chief of Staff told the OIG that in response to the OIG referral referenced above, that a management level review of the subject ophthalmologist's care of patients was initiated. The Chief of Quality, Safety, and Value told the OIG that the decision to conduct the management review was "made strictly based off of the OIG hotline. At that time, we had no concerns other than what was written in the OIG hotline."

The management review consisted of an external ophthalmologist evaluating 20 randomly selected patient cases managed by the subject ophthalmologist to determine whether: (1) comprehensive assessments, including pre and post procedure, were complete; (2) documented plan of care was appropriate; (3) postoperative care was appropriate; (4) resident supervision and documentation of supervision was appropriate; and (5) overall standard of care was met.[16] The external ophthalmologist answered "yes" to all assessment criteria and had no concerns with the care of the 20 patients. The OIG conducted an interview with the external ophthalmologist who confirmed having no concerns with the patient care and documentation provided by the subject ophthalmologist after reviewing the patients' EHRs.

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[13] VHA Handbook 1121.01.

[14] American Academy of Ophthalmology, Summary Benchmarks for Preferred Practice Pattern® Guidelines, October 2016, accessed on November 9, 2020, https://www.aao.org/summary-benchmark-detail/summary-benchmarks-full-set-2019.

[15] VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

[16] For the purposes of this review, the OIG defines external ophthalmologist as an ophthalmologist that is employed at another VA medical facility.

The OIG conducted an independent review of the same 20 patient cases and determined that in all 20 cases, the evaluation, treatment, procedure, follow-up, and documentation were in alignment with VHA policy and professional guidelines.

In an interview with the OIG, the Chief of Staff, the subject ophthalmologist's direct supervisor, reported there were no concerns with the subject ophthalmologist's quality of care and documentation and that it compared similarly to the other ophthalmologists. Additionally, the Facility Director had no concerns with the subject ophthalmologist's quality of care.

When interviewed by the OIG, the complainant reported there had been an improvement in how the subject ophthalmologist provided and documented patient care. Reportedly, the improvements began after the onset of the coronavirus (COVID-19) shutdown at the facility. The complainant reported no continued concerns with the subject ophthalmologist's quality of care and documentation.

The OIG found, besides the single patient case, no deviations from VHA policy and AAO guidelines related to the provision and documentation of care provided by the subject ophthalmologist.

Conclusion

The OIG substantiated that the subject ophthalmologist failed to provide adequate resident supervision and falsified documentation related to supervision for a single patient case. The OIG determined that residents were unable to reach the subject ophthalmologist when a patient experienced continued decrease in vision and that the subject ophthalmologist did not arrange for attending coverage when away from the clinic. The unedited template used by the subject ophthalmologist to document supervision of the encounter was inaccurate because the subject ophthalmologist did not directly participate in, and was not present during, the care of the patient.

Aside from the single patient case, the OIG did not identify any other failures to supervise residents or falsify documentation of resident supervision by the subject ophthalmologist. During the OIG review, no additional dates or patient names where the subject ophthalmologist was not available for resident supervision was provided by residents, attending ophthalmologists, or other staff. Facility reviews identified documented evidence of resident supervision and no additional concerns were identified. Additionally, during interviews, facility leaders stated the subject ophthalmologist is no longer providing resident supervision due to a request in change of duties which included no longer supervising residents.

The OIG did not substantiate that the subject ophthalmologist failed to supervise residents who performed injections and laser procedures. The OIG did not learn, besides the patient case in summer 2019, of reports of residents performing injections or laser procedures without proper training or supervision.

A review of 20 patients performed by an external ophthalmologist and the OIG determined the subject ophthalmologist provided quality of care and appropriate documentation. The subject ophthalmologist, aside from the single patient case, provided and documented proper patient care following VHA Handbook 1121.01and AAO guidelines. The complainant reported having no continued concerns about the subject ophthalmologist's quality of care and documentation.

Recommendations 1–3

1. The Oklahoma City VA Health Care System Director ensures a review of the clinic note for the patient who experienced temporary loss of vision and confirms that the level of supervision provided by the attending ophthalmologist is accurately reflected in the electronic health record.

2. The Oklahoma City VA Health Care System Director conducts a review to ensure that language used to document resident supervision accurately reflects the presence of the attending ophthalmologist and the degree of resident oversight provided and takes action as indicated.

3. The Oklahoma City VA Health Care System Director confirms that ophthalmology service procedures include a hand-off process to address attending coverage in situations when an attending ophthalmologist is unavailable to provide timely resident supervision.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 21, 2021

From: Director, VA Rocky Mountain Network (10N19)

Subj: Healthcare Inspection—Inadequate Resident Supervision and Documentation of an Ophthalmology Procedure at the Oklahoma City VA Health Care System in Oklahoma

To: Director, Office of Healthcare Inspections, Seattle (54HL05)

Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. We appreciate the opportunity to work with the Office of Inspector General as we continuously strive to improve the quality of healthcare for America's Veterans.

2. I have reviewed and concur with the Oklahoma City VA Healthcare System response and plan of action for each recommendation.

3. If you have any questions, please contact the VISN 19 Quality Management Specialist.

(*Original signed by*:)

Ralph T. Gigliotti, FACHE
Director, VA Rocky Mountain Network (10N19)

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 20, 2021

From: Director, Oklahoma City VA Health Care System (635)

Subj: Healthcare Inspection—Inadequate Resident Supervision and Documentation of an Ophthalmology Procedure at the Oklahoma City VA Health Care System in Oklahoma

To: Director, VA Rocky Mountain Network (10N19)

1. Thank you for the opportunity to review and respond in the draft report, Healthcare Inspection-Inadequate Resident Supervision and Documentation of an Ophthalmology Procedure at the Oklahoma City VA Health Care System in Oklahoma.

2. I have reviewed and concur with the recommendations 1-3 in the draft report. Corrective actions have been developed or implemented and are identified in the Directors Comments.

3. If you have additional questions, please contact the Chief, Quality Management.

(*Original signed by*:)

Wade Vlosich
Health Care System Director

Facility Director Response

Recommendation 1

The Oklahoma City VA Health Care System Director ensures a review of the clinic note for the patient who experience temporary loss of vision and confirms that the level of supervision provided by the attending ophthalmologist is accurately reflected in the electronic health record.

Concur.

Target date for completion: 4/30/2021

Director Comments

The attending Ophthalmologist drafted an addendum to be scanned into the medical record to adequately reflect the appropriate supervision.

OIG Comment

The OIG considers this recommendation closed based upon submission of documentation to support closure.

Recommendation 2

The Oklahoma City VA Health Care System Director conducts a review to ensure that language used to document resident supervision accurately reflects the presence of the attending ophthalmologist and degree of resident oversight provided and takes action as indicated.

Concur.

Target date for completion: 8/31/2021

Director Comments

A random review of 50 resident supervision encounters will be performed by a Quality Improvement Nurse until three consecutive months of 90% compliance is met to ensure the degree of resident oversight was appropriately reflected in the electronic health record.

Recommendation 3

The Oklahoma City VA Health Care System Director confirms that ophthalmology service procedures include a hand-off process to address attending coverage in situations when an attending ophthalmologist is unavailable to provide timely resident supervision.

Concur.

Target date for completion: 8/31/2021

Director Comments

The Associate Chief of Staff for Education performed daily observation to ensure attending was present and reviews indicated 100% compliance. The Associate Chief of Staff will continue to complete random weekly observations for three months to ensure sustained compliance.

Glossary

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

anterior chamber tap. A procedure in which a needle is inserted into the anterior chamber of the eye and fluid is removed. This procedure can be utilized to reduce pressures in the eye before or after an intravitreal injection.[1]

anti-VEGF injection. An injection used to administer a medication that stops the growth of new blood vessels in the eye at times when these new blood vessels can lead to low vision or blindness. These injections can be used to treat wet age-related macular degeneration, macular edema, diabetic retinopathy, and retinal vein occlusion.[2]

coronavirus. Coronavirus disease (COVID-19) is a newly discovered infectious disease. It can be spread from person to person through droplet secretions, such as a cough or sneeze.[3]

exudate. Deposits of fats, proteins, and other substances that leak out of blood vessels in the back of the eye. These deposits can lead to decreased vision based on where they are in the eye.[4]

graduated levels of responsibility. Progressive responsibility earned by residents to provide patient care without a supervising practitioner present.[5]

hypertensive retinopathy. A condition effecting the retina of the eye due to chronically elevated blood pressure. Untreated blood vessels in the eye can leak fluids leading to damage to fat deposits or exudates on the retina and injuring blood vessels. Patients may initially complain of eye pain and headaches. Some patients with this condition have been treated with anti-VEGF injections.[6]

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[1] Sandeep Saxena et al., "Anterior chamber paracentesis during intravitreal injections in observational trials: effectiveness and safety and effects" *International Journal of Retina and Vitreous* 5, 8: 2019, https://doi.org/10.1186/s40942-019-0157-z.

[2] American Academy of Ophthalmology, *Anti-VEGF Treatments*, accessed November 30, 2020, https://www.aao.org/eye-health/drugs/anti-vegf-treatments.

[3] World Health Organization (WHO), *Coronavirus,* accessed August 4, 2020*,* https://www.who.int/health-topics/coronavirus#tab=tab_1.

[4] Columbia University Department of Ophthalmology, *Hard Exudates*, accessed November 30, 2020, https://www.columbiaeye.org/education/digital-reference-of-ophthalmology/vitreous-retina/retinal-vascular-diseases/hard-exudates.

[5] VHA Handbook 1400.01.

[6] American Academy of Ophthalmology, *EyeWiki: Hypertensive retinopathy,* accessed November 30, 2020, https://eyewiki.aao.org/Hypertensive_retinopathy.

indirect supervision. Supervision exercised by a supervising practitioner who is not physically present with the resident and the patient during the patient encounter, procedure, or episode of care.[7]

intraocular pressure. A measurement of the pressures found in the liquid parts of the eye. When pressures in the fluids are too high, they can damage the optic nerve and lead to blindness.[8]

intraretinal fluid. Liquid found within the layers of the retina.[9]

intravitreal injection. A procedure performed in the office setting to "place a medication directly into the back of the eye called the vitreous cavity." The medications are used to treat retinal conditions.[10]

macular edema. The build-up of fluid in the macula, an area in the center of the retina. The retina is the light-sensitive tissue at the back of the eye and the macula is the part of the retina responsible for sharp, straight-ahead vision. Fluid build-up causes the macula to swell and thicken, which distorts vision.[11]

non-proliferative diabetic retinopathy. A condition when the increased sugars in the blood due to diabetes effect blood vessels in the retina of the eye. In the early stages of this condition **s**mall blood vessels of the eye can leak or close off leading to decreased blood flow or exudates to form on the retina leading to changes in vision over time.[12]

ocular massage. A technique of applying manual pressure to the eye with the fingers and hands. Various types of massage procedures are simple techniques used to manage a variety of eye problems.[13]

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[7] VHA Handbook 1400.01.

[8] American Academy of Ophthalmology, *Eye health A-Z: Eye pressure*, accessed November 30, 2020, https://www.aao.org/eye-health/anatomy/eye-pressure.

[9] Merriam Webster Dictionary, "Definition of Intraretinal," accessed December 1, 2020, https://www.merriam-webster.com/medical/intraretinal.

[10] American Society of Retina Specialists, *Intravitreal Injections,* accessed August 27, 2020, https://www.asrs.org/patients/retinal-diseases/33/intravitreal-injections.

[11] National Eye Institute, *Macular Edema,* accessed November 30, 2020, https://www.nei.nih.gov/learn-about-eye-health/eye-conditions-and-diseases/macular-edema#:~:text=Diabetic%20macular%20edema%20%28DME%29%20is%20caused%20by%20a,age%20Americans.%20Diabetic%20retinopathy%20usually%20affects%20both%20eyes.

[12] American Academy of Ophthalmology, *Eye health A-Z: Diabetic retinopathy,* accessed November 30, 2020, https://www.aao.org/eye-health/diseases/what-is-diabetic-retinopathy.

[13] Mahmood Ali et al., "Ocular Digital Massage for the Management of Post-Trabeculectomy Underfiltering Blebs" *Journal of the Collee of Physicians and Surgeons Pakistan*, vol. 21 (11): 2011.

ophthalmologist. A physician who specializes in examination, diagnosis, and treatment of the eye.[14]

ophthalmology. Ophthalmology is a medical specialty concerned with "the structure, functions, and diseases of the eye."[15]

perifoveal. A region located around a circular depression in the center of the retina of the eye called the fovea.[16]

[14] American Academy of Ophthalmology, *What is an Ophthalmologist?*, accessed July 17, 2020, https://www.aao.org/eye-health/tips-prevention/what-is-ophthalmologist.

[15] Merriam-Webster, "Definition of Ophthalmology," accessed November 17, 2020, https://www.merriam-webster.com/dictionary/ophthalmology.

[16] Myron Yanoff, Jay S. Duker. *Ophthalmology, 5th ed.,* Elsevier, 2019. "Chapter 6.1 Structure of the Neural Retina," pgs. 419-422.e1.

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