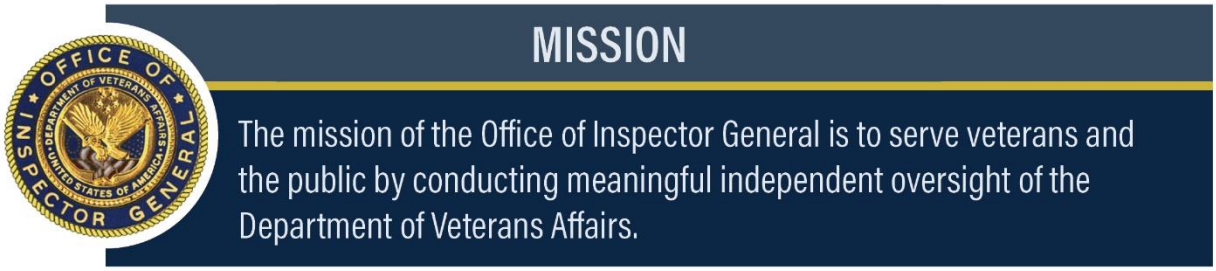
DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Failure of a Primary Care Provider to Complete Electronic Health Record Documentation and Inadequate Oversight at the Charlie Norwood VA Medical Center in Augusta, Georgia

HEALTHCARE INSPECTION | REPORT #20-00354-178 | JULY 1, 2021



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Charlie Norwood VA Medical Center (facility) in Augusta, Georgia, to evaluate a primary care provider's (provider) completion of electronic health record (EHR) documentation within the facility's required time frame and an accumulation of over 4,000 view alerts that may have resulted in patients' adverse clinical outcomes.[1] View alerts are notifications sent to providers through the EHR that communicate clinical and administrative information.[2] Clinical view alerts may need further action from a provider. The OIG also reviewed actions taken by facility leaders to address the provider's EHR documentation deficiencies.

On August 28, 2019, the OIG received the following allegations:

- The provider failed to complete EHR documentation within the required time frame set by Veterans Health Administration (VHA) and facility policies.
- The provider accumulated over 4,000 view alerts.[3]

On October 21, 2019, the OIG sent the allegations to facility leaders for review and response. The Facility Director substantiated the allegations, and the OIG received the response on December 10, 2019. After reviewing the response, the OIG opened a healthcare inspection to evaluate the following concerns:

1. Patients' adverse clinical outcomes as a result of the provider not completing EHR documentation (progress notes) per facility policy
2. Patients' adverse clinical outcomes as a result of the provider's accumulation of view alerts
3. Facility leaders' response to the provider's documentation deficiencies

[1] The provider worked at a facility community-based outpatient clinic. Within the context of this report, the OIG considered an adverse clinical outcome to be death, a progression of disease, worsening prognosis, suboptimal treatment, or a need for higher level care.

[2] VA Office of Information and Technology, Product Development, *Computerized Patient Record System (CPRS)* Technical Manual *V. 1.0*, November 2018. The 2018 Technical Manual covers the time frame of interest in this report and was rescinded and replaced by the VA Office of Information and Technology, *Computerized Patient Record System* (CPRS) *User Guide: GUI Version*, June 2020. Both the 2018 and 2020 manuals have the same or similar language about view alerts. Unaddressed view alerts do not necessarily correlate to unmanaged clinical results or administrative consults.

[3] The complainant reported the provider had over 4,000 unaddressed view alerts on August 28, 2019. View alerts are removed from the system once addressed and are no longer viewable; the number of view alerts may change throughout each day.

During the inspection, the OIG identified two additional concerns:

- Health Information Management staff were not monitoring EHRs for patient care episodes without an associated progress note [4]
- A facility policy did not define the time frame for providers to monitor and respond to view alerts as required by VHA[5]

1. EHR Documentation

The OIG received the names of 220 of the provider's patients that were identified by the complainant or facility leaders as having documentation deficiencies. The provider failed to complete progress notes within the facility required time frame of 72 hours.[6] The OIG determined that 20 of the 220 identified patient records reviewed did not have an associated progress note for patient care episodes. Timely and complete EHR documentation enables communication between healthcare professionals and facilitates a provider's ability to access clinical information to assist in assessing and determining patient care decisions, as well as monitoring a patient's health over time.[7] The OIG did not identify patients who experienced an adverse clinical outcome as a result of the documentation deficiencies.

Facility leaders confirmed that there were provider vacancies that resulted in an increase in the number of patients assigned to providers. A facility leader reported that the provider did not have a larger panel than any other provider but had difficulty completing documentation prior to the increase in panel size. The facility data indicated the provider's panel size of a little over 1,000 patients increased about 30 percent from early 2018 to summer 2019.

The provider identified reasons for not completing documentation that included a lack of administrative time, provider staffing shortages resulting in caring for additional patients, and personal issues. The provider acknowledged that completing the documentation was important; however, the provider stated that completing tasks, such as medication renewal, and reviewing and addressing abnormal laboratory and diagnostic results, were a priority over documenting the patient care episode.

2. Provider View Alerts

The OIG was unable to determine if patients experienced adverse clinical outcomes resulting from the provider accumulating 4,000 view alerts. By fall 2019, the provider had addressed the 4,000 view alerts. The OIG was unable to review these view alerts, because once addressed, the

[4] For this report, the term *patient care episode* refers to an encounter, appointment, or provider visit.

[5] VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015. This handbook is scheduled for recertification on or before the last working day of March, 2020.

[6] Facility Policy 112-18-07, *Documentation and Completion of Health Records*, October 26, 2018.

[7] VHA Handbook 1907.01.

notifications were no longer active or viewable. Per facility leaders, no adverse clinical outcomes were identified.

During the inspection, the OIG was informed that while setting up a backup alert system on March 5, 2020, an information technology programmer inadvertently purged all view alerts over 14 days old from the facility's computer system. Facility leaders told the OIG that programmers were able to use a backup system to locate purged alerts from October 1, 2019, through March 5, 2020. Pertinent view alerts were distributed to providers to take appropriate actions to address patient needs.

3. Facility Leader's Response

Facility leaders and the provider acknowledged that the provider had amassed a large number of view alerts, which were addressed during the provider's administrative suspension of three days. The provider reported a process for triaging view alerts at the end of day due to time constraints and prioritized the alerts by date received, medications requiring timely refills, and patient calls. A staff member informed the OIG there were no administrative reviews for the provider including quality reviews, patient incident reports, or peer reviews.

Facility leaders implemented actions to address the provider's long-standing documentation deficiencies, but they were not effective. Facility leaders addressed this issue by instituting several focused professional practice evaluations (FPPE) for cause for the provider.[8] Although the provider's documentation steadily improved with each FPPE, the OIG noted a cyclical pattern. After the provider met FPPE expectations and clinical leaders rated the FPPE as successful, the provider reverted to deficient documentation practices.

Facility leaders reported they provided counseling, sent emails, offered voice recognition and electronic medical record software, and conducted performance evaluations as well as provider proficiency reports. Facility leaders consulted with Human Resources and the Office of Medical Legal Affairs for guidance on the provider's continued employment. Facility leaders continued to monitor the provider for sustainable compliance with documentation requirements. The Chief of Staff informed the OIG that the provider was no longer treating patients at the facility.

According to VHA policy, the Chief of the Health Information Management program is responsible for records management and EHR reviews to ensure timely, complete, and properly authenticated documentation. Results of reviews must be reported to the Health Information Management Committee.[9] The OIG did not find evidence that facility EHRs were monitored for

[8] VHA Handbook 1100.19, *Credentialing and Privileging,* October 15, 2012. A Focused Professional Practice Evaluation for cause is time limited and allows facility leaders to evaluate a practitioner's professional performance when questions arise pertaining to a currently privileged practitioner's ability to provide safe, high-quality patient care.

[9] VHA Handbook 1907.01.

patients' episodes of care without associated progress notes. The Chief of Health Information Management position was vacant for approximately four years. The absence of a permanent Chief of Health Information Management contributed to facility leaders' failure to focus on monitoring EHRs for patient care episodes without an associated progress note. The OIG concluded that if monitoring for the patient care episodes without an associated progress note had been performed, they may have identified the provider's missing documentation sooner.

VHA policy requires providers to monitor and respond promptly with appropriate action on view alerts, and facility policy should define the time frame for those actions.[10] The OIG found that the facility did not have a policy with the required time frame. However, the Chief of Staff reported that clinical leaders reviewed the number of alerts for each provider on a weekly basis, held providers accountable for managing alerts, and planned to implement disciplinary action for providers who accumulated alerts.

In February 2020, facility leaders implemented strategies to reduce the number of unnecessary view alerts that providers received. Facility data showed a reduction of accumulated view alerts. For example, providers in the primary care service had 14,150 unaddressed view alerts the week of March 10, 2020; and by the week of June 16, 2020, the number of unaddressed view alerts had decreased to 9,170. Facility leaders and staff attributed some of the reduction to the decreased number of patients seen secondary to COVID-19. The OIG recognized that high numbers of accumulated view alerts were not isolated to the provider. The OIG concluded that facility leaders will need to continue to develop and implement strategies to manage view alerts, evaluate the effectiveness, and assess the need for retrospective reviews of patient care related to accumulated view alerts.

The OIG made three recommendations to the Facility Director related to monitoring EHRs for patient care episodes without an associated progress note, defining the time frame providers are required to respond to view alerts, and monitoring providers' responses to view alerts.

[10] VHA Handbook 1907.01.

Comments

The Veterans Integrated Service Network and Facility Director concurred with the recommendations and provided acceptable action plans (see appendixes B and C). The OIG considers all recommendations open and will follow up on the planned and recently implemented actions to ensure they have been effective and sustained.

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Contents

Abbreviations

EHR	electronic health record
FPPE	focused professional practice evaluation
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted an inspection at the Charlie Norwood VA Medical Center (facility) to evaluate a primary care provider's (provider) completion of electronic health record (EHR) documentation within the facility's required time frame and an accumulation of over 4,000 view alerts that may have resulted in patients' adverse clinical outcomes.[1] The OIG also reviewed actions taken by facility leaders to address the provider's EHR documentation deficiencies.

Background

The facility is a part of Veterans Integrated Service Network (VISN) 7 and has two divisions that are located in Uptown and Downtown Augusta, Georgia. The facility has three community-based outpatient clinics in Athens and Statesboro, Georgia; and Aiken, South Carolina.[2] The Veterans Health Administration (VHA) classifies the facility as a complexity level 1a, the most complex.[3] From October 1, 2018, through September 30, 2019, the facility served 46,428 patients. The facility offers a wide variety of inpatient and outpatient services.

View Alerts

View alerts are notifications sent to providers through the EHR that communicate clinical information, such as the results of laboratory tests, diagnostic imaging, and diagnostic

[1] The provider worked at a facility community-based outpatient clinic. VA Office of Information and Technology, Product Development, *Computerized Patient Record System (CPRS) Technical Manual V. 1.0*, November 2018. The 2018 manual covers the time frame of interest in this report and was rescinded and replaced by VA Office of Information and Technology, *Computerized Patient Record System* (CPRS) *User Guide: GUI Version*, June 2020. Both the 2018 and 2020 manuals have the same or similar language stating that view alerts are notifications sent to providers through the EHR that communicate clinical and administrative information. Within the context of this report, the OIG considered an adverse clinical outcome to be death, a progression of disease, worsening prognosis, suboptimal treatment, or a need for higher level care.

[2] VHA, *About VHA*, accessed May 4, 2020, https://www.va.gov/health/aboutVHA.asp. VHA established community-based outpatient clinics settings to "provide the most common outpatient services, including health and wellness visits, without the hassle of visiting a larger medical center."

[3] VHA Office of Productivity, Efficiency and Staffing, "Facility Complexity Level Model Fact Sheet," December 15, 2017. The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, and educational and research missions. Complexity levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex and level 3 facilities are the least complex. At the time of the events discussed in this report, the facility was a complexity level 1a; in January 2021, the level was changed to 1b.

procedures.[4] View alerts also include administrative information, such as the scheduling of an appointment related to a consult.[5] Some view alerts are mandatory while other view alerts are optional.[6]

View alerts are one tool for communicating test results. It is possible for providers to manage the test result regardless of whether or not they address the view alert. Provider's address the view alert by opening it and viewing the result or communication. Clinical view alerts may need further action from a provider. Unaddressed view alerts do not necessarily correlate to unmanaged clinical results or administrative information.

VHA policy states that facility leaders should evaluate the numbers and types of view alert notifications providers receive to ensure alerts are "effective, responded to in a timely manner, and do not create unnecessary information burdens on ordering providers or designees," and a memorandum recommends optimizing their use by limiting the number of mandatory alerts.[7] In May 2017, the VHA Deputy Under Secretary for Health Operations and Management view alerts optimization reporting site indicated that facility providers received an average of 170 view alerts a day.

Allegations and Related Concerns

On August 28, 2019, the OIG received the following allegations:

- The provider failed to complete EHR documentation within the required time frame set by VHA and facility policies.
- The provider accumulated over 4,000 view alerts.[8]

On October 21, 2019, the OIG sent the allegations to facility leaders for review and response. According to the Facility Director's response received on December 10, 2019, the Chief of Primary Care completed an internal review that substantiated the allegations. After reviewing the facility leaders' response, the OIG identified concerns about patients' possible adverse clinical

[4] VA Office of Information and Technology, Product Development, *Computerized Patient Record System (CPRS) Technical Manual V. 1.0*, November 2018. The 2018 manual covers the time frame of interest in this report and was rescinded and replaced by the VA Office of Information and Technology, *Computerized Patient Record System* (CPRS) *User Guide: GUI Version*, June 2020. Both the 2018 and 2020 manuals have the same or similar language stating that view alerts are notifications sent to providers through the EHR that communicate clinical and administrative information. VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.

[5] VHA Directive 1232(2), *Consult Processes and Procedures,* August 24, 2016.

[6] VA Office of Information and Technology, *Computerized Patient Record System (CPRS) User Guide: GUI Version*, June 2020.

[7] VHA Directive 1088; VHA Deputy Under Secretary for Health Operations and Management Memorandum, *View Alerts Optimization Program*, March 8, 2017.

[8] The complainant reported the provider had over 4,000 unaddressed view alerts in summer 2019. View alerts are removed from the system once addressed, and the number of view alerts may change throughout each day.

outcomes related to documentation deficiencies. The OIG opened a healthcare inspection to further evaluate

1. Patients' adverse clinical outcomes as a result of the provider not completing EHR documentation per facility policy,
2. Patients' adverse clinical outcomes as a result of the provider's accumulation of view alerts, and
3. Facility leaders' response to the provider's documentation deficiencies.

During the inspection, the OIG identified two additional concerns:

- The facility's Health Information Management staff were not monitoring the EHRs for patient care episodes without an associated progress note.[9]
- A facility policy did not define the time frame for providers to monitor and respond to view alerts as required by VHA.[10]

Prior OIG Reports

In the July 2019 report, *Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center,* the OIG identified concerns with facility staff not feeling supported by leaders, an inefficient hiring process, and inadequate communication of policies, among other administrative issues. The OIG made 27 recommendations, two of which remained open as of June 14, 2021.[11]

In the May 2020 report, *Critical Care Unit Staffing and Quality of Care Deficiencies at the Charlie Norwood VA Medical Center, Augusta, Georgia*, the OIG outlined non-compliant practices and other deficits that contributed to adverse patient events and clinical outcomes. Due to the lack of consistent documentation, the OIG was unable to determine whether insufficient nurse staffing contributed to many of the patient events outlined in the allegations. The OIG identified concerns with compliance with VHA and facility requirements related to nursing practices documentation, evaluation of the circumstances surrounding the respiratory care for a patient, processes for securing sitters, and nurse staff assignment practices. The OIG made six recommendations, which were closed as of June 14, 2021.[12]

In the September 2020 report, *Deficiencies in Care and Excessive Use of Restraints for a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia*, the OIG identified

[9] For this report, the term *patient care episode* refers to an encounter, appointment, or provider visit.

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

[11] VA OIG, *Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center, Augusta, Georgia*, Report No. 19-00497-161, July 11, 2019.

[12] VA OIG, *Critical Care Unit Staffing and Quality of Care Deficiencies at the Charlie Norwood VA Medical Center, Augusta, Georgia*, Report No. 19-08296-118, May 12, 2020.

that care deficiencies likely contributed to a patient's death. The OIG identified other concerns related to documentation, mismanagement of the patient's mental health needs, deficient Disruptive Behavior Committee processes and oversight, and facility leaders' insufficient review and response to the patient's death. The OIG made 18 recommendations, five of which remained open as of June 14, 2021.[13]

In the December 2020 report, *Surgical Service Care Deficiencies in the Critical Care Unit at the Charlie Norwood VA Medical Center in Augusta, Georgia*, the OIG identified deficiencies in care coordination between facility staff and tele-ICU staff after general surgery residents were removed but was unable to determine that the absence of surgery residents resulted in deaths, injuries, or poor outcomes for patients identified in the complaint. The OIG found facility leaders were aware of the removal of the residents but did not take actions to mitigate potential issues. The OIG identified other concerns related to communication and coordination, on-call processes, medicine and surgery staff responsibilities, patient safety reporting training, quality review collaboration processes, orientation and competency training, and coordination of patient care reviews. The OIG made eight recommendations, which remained open as of June 14, 2021.[14]

In the March 11, 2021, report, *View Alert Process Failures and the Impact on Patient Care at the Central Alabama Veterans Health Care System in Montgomery,* the OIG identified concerns that some patients' care was compromised because abnormal laboratory and imaging results were either not managed or not managed within the required timeframe. Some patients were at risk for delayed cancer diagnoses because of the lack of timely provider follow-up. The OIG also found that the ordering providers did not consistently take appropriate actions to edit and resubmit canceled consults. The OIG did not substantiate that at least 12 providers had each accumulated more than 5,000 view alerts, or that the system excluded teleradiologists from the requirement to communicate abnormal and critical test results to ordering providers or their designees. The OIG made one recommendation to the Under Secretary for Health, one recommendation to the VA Southeast Network Director, and nine recommendations to the Facility Director, which remained open as of June 14, 2021.[15]

[13] VA OIG, *Deficiencies in Care and Excessive Use of Restraints for a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia*, Report No. 19-08106-273, September 30, 2020.

[14] VA OIG, *Surgical Service Care Deficiencies in the Critical Care Unit at the Charlie Norwood VA Medical Center in Augusta, Georgia*, Report No. 20-01480-31, December 16, 2020.

[15] VA OIG, *View Alert Process Failures and the Impact on Patient Care at the Central Alabama Veterans Health Care System in Montgomery*, Report No. 20-00427-92, March 11, 2021.

Scope and Methodology

The OIG initiated the inspection on February 12, 2020. Due to the COVID-19 pandemic, the VISN 7 Director requested a 60-day hold.[16] The OIG granted the hold, and on June 15, 2020, resumed work on the inspection. The OIG conducted a virtual site visit June 22–25, 2020.

Interviews included the Facility Director; Chief and Deputy Chief of Staff; Acting Chief of Primary Care; Clinical Application Coordinators; current and former Acting Chiefs of Quality Management; Chief of Health Information Management; a community-based outpatient clinic nurse manager; Human Resources Labor Relations/Employee Relations Supervisor; Compliance, Business, and Integrity Officer; the provider; and primary care providers.

The OIG team reviewed VHA directives, handbooks, and memorandum; facility policies and procedures; meeting minutes of the Executive Council Medical Staff, Peer Review Committee, and Medical Records Committee; facility Human Resources and personnel documents; facility view alert data; and the Facility Director's response to the OIG.

The OIG reviewed the EHRs of 220 of the provider's patients identified by the complainant or facility leaders as having documentation deficiencies related to the subject provider.[17] The OIG developed a risk stratification tool to apply while reviewing the EHRs. The tool provided guidance to identify patient care episodes as high, medium, or low risk; evaluate if the provider

[16] World Health Organization, WHO Director-General's opening remarks at the media briefing on COVID-19 – 11, accessed October 22, 2020, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020. Merriam Webster, *Definition of pandemic*. A pandemic is a disease outbreak over a wide geographic area that affects most of the population, accessed October 22, 2020, https:/www.merriam-webster.com/dictionary/pandemic. COVID-19 is caused by the "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)," a newly discovered coronavirus. The World Health Organization, *Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It,* accessed October 22, 2020, https://gcc01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.who.int%2Femergencies%2Fdiseases%2Fnovel-coronavirus-2019%2Ftechnical-guidance%2Fnaming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it&data=04%7C01%7C%7C8db553dad01240178d5008d88590ede2%7Ce95f1b23abaf45ee821db7ab251ab3bf%7C0%7C0%7C637406204790395416%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=JkyvQQqvLJSPqKIvQIW1ZGWLxasl0zBIaYl0CHx3DVQ%3D&reserved=0.

[17] The review time frame of the 220 identified patients' EHRs was from March 21, 2018, to July 18, 2019.

addressed the patient's chief complaint; and determine if lack of documentation affected the quality or coordination of a patient's care.[18]

The OIG team identified a possible data limitation for this review. The OIG was informed that an information technology programmer inadvertently purged all view alerts from the facility's computer system and was unable to recover alerts that occurred prior to October 1, 2019.

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.

[18] The risk stratification tool the OIG team used for this review defined the following: Low risk is a regular or routine follow-up such as an annual or semi-annual physical, physical for work, or follow-up for a chronic condition such as diabetes or high blood pressure; Medium risk is an urgent visit for a focused problem that is noncomplex such as a cold, upper respiratory infection, low back pain, headache (mild or moderate), strain or sprains, gastrointestinal upset, or urinary complaints that would be unlikely to progress to hospitalization; and High risk is an urgent problem that may denote a serious medical condition such as cardiopulmonary (heart and lung) issues including congestive heart failure, chest pain, shortness of breath, gastrointestinal bleed, systemic infection, cancer, or life and limb threatening conditions. In general, high risk indicates a condition that requires medical staff to intervene urgently to prevent imminent hospitalization of a patient.

Inspection Results

1. Clinical Care Evaluation

The OIG did not identify patients who experienced an adverse clinical outcome as a result of the provider's failure to complete EHR documentation or complete documentation within the 72-hour time frame set by facility policy.[19] The OIG determined that facility leaders implemented actions to address the provider's EHR documentation deficiencies.

According to VHA policy, providers must enter documentation of each event of a patient's care into the EHR. Specifically, facility staff "must maintain complete, accurate, timely, clinically-pertinent, and readily-accessible patient health records, which contain sufficient recorded information to serve as a basis to plan patient care, support diagnoses, warrant treatment, measure outcomes, support education, research, and facilitate performance improvement processes and legal requirements." Timely and complete EHR documentation enables communication between healthcare professionals and facilitates a provider's ability to access clinical information to assist in assessing and determining patient care decisions, as well as monitoring a patient's health over time.[20] Facility policy requires that primary care providers document progress notes in the patient's EHR within 72 hours of each episode or event of care.[21]

The OIG reviewed 220 EHRs of patients seen by the provider. The provider failed to complete progress notes associated with episodes of patient care or failed to complete notes within the required time frame of 72 hours. The patient care episodes occurred from January 18, 2018, through July 24, 2019. The OIG found that the length of time between patient care episodes and the provider's documentation completion was from the same day up to 148 days. Of the patients reviewed, the OIG did not identify adverse clinical outcomes related to delinquent documentation.

Contributing Factors of Incomplete EHR Documentation

The OIG interviewed facility leaders and primary care providers to discuss the provider's documentation of progress notes. The provider identified reasons for not completing the documentation that included a lack of administrative time, provider staffing shortages resulting in caring for additional patients, and personal health issues. The provider acknowledged that completing the documentation was important but stated "you try to address the things that are imminent in the health of the patient immediately, and that's how I I [*sic*] prioritized it, and left the notes." The provider stated that completing tasks, such as medication renewals and reviewing

[19] Facility Policy 112-18-07, *Documentation and Completion of Health Records*, October 26, 2018.
[20] VHA Handbook 1907.01.
[21] Facility Policy 112-18-07.

and addressing abnormal laboratory and diagnostic results, were a priority over documenting the patient care episode.

The OIG interviewed another primary care provider who reported dedicated administrative time to complete tasks that included documenting patient care, meetings, addressing secure messaging, and other organizational duties. Administrative time was filled quickly with competing obligations, and although keeping up with view alerts and secured messaging was challenging, this primary care provider reported that completing progress notes was not a problem. Facility leaders confirmed providers' requirement to book 32 hours of patient appointments per week, and the additional 8 hours for administrative time, that included meetings, were spread throughout the week.

Facility leaders and a primary care provider who were interviewed confirmed there were provider vacancies that resulted in an increase in the number of patients assigned to providers. A facility leader reported that due to increased vacancies in 2018, some provider panel sizes (the number of patients assigned to a provider) increased from the facility maximum of 1,200 patients to as many as 1,400. However, another facility leader stated the provider did not have a larger panel than any other provider, but the provider had difficulty completing documentation prior to the increase in panel size. The facility data indicated the provider's panel size of a little over 1,000 patients increased about 30 percent from early 2018 to summer 2019.

The provider reported either placing a progress note directly in the EHR or noting bullet points in a Microsoft Word document that was stored in the VA computer system and later retrieved for entry into the EHR. The provider stated it was easier and faster to type bullet points into a Word document during the patient visit, and then move on to the next patient. Although the OIG noted this practice created additional steps to the documentation process, having the Word document notes allowed the provider a reference to more accurately complete delinquent progress notes. However, VHA requires patient care documentation be entered directly into and stored in the EHR.[22]

2. Provider View Alerts

The OIG was unable to determine if adverse clinical outcomes resulted from the provider accumulating 4,000 view alerts. Facility leaders reported that the provider addressed the 4,000 view alerts by fall 2019, prior to the OIG inspection. Facility leaders stated that they found no adverse clinical outcomes resulting from the accumulated view alerts. The OIG was unable to

[22] VHA 1907.01; VHA Directive 1080, *Access to Personally Identifiable Information in Information Technology System,* January 6, 2017. The OIG was informed that once facility leaders were aware that the provider stored patient care information in a Word document before transferring the information to approved VHA software, the Information Security Officer was notified. The Information Security Officer provided additional training to the provider. VA Handbook 6500*, Risk Management Framework for VA Information Systems-Tier 3: VA Information Security Program.* March 10, 2015. VA requires clinical staff to safeguard personally identifiable information and report any occurrences of disclosure to the Information Security Officer.

review the provider's 4,000 accumulated view alerts, because once addressed, the notification was no longer active or viewable. Because a full evaluation of the provider's view alerts could not be completed, the OIG requested quality documents, including patient safety incidents and peer reviews related to view alerts for the provider.

Recovered View Alerts

During the inspection, a Clinical Applications Coordinator informed the OIG that while setting up a backup alert system on March 5, 2020, an information technology programmer (programmer) inadvertently purged all view alerts over 14 days old from the facility's computer system. Programmers attempted but were unable to restore all the deleted view alerts. However, the OIG was informed that programmers were able to use a backup system to locate alerts from October 1, 2019, through March 5, 2020, and copied those view alerts into a file. A facility administrative officer identified alerts containing abnormal and critical results for patients of all primary care providers and distributed the list to service chiefs with instructions for providers to review the results and take appropriate actions to address patient needs.

View Alerts Accumulated by the Provider

Facility leaders and the provider acknowledged that the provider had amassed a large number of view alerts, which were addressed during the provider's suspension period. The provider reported a process for triaging view alerts due to time constraints. The provider described prioritizing the alerts according to the date received, medications requiring timely refill, and responding to patient calls. The provider stated that view alerts are reviewed at the end of the day, and tried to address the important ones. For example, the provider described looking at medication refills and patient calls, as well as outside calls, and tried to address laboratory results while the patient was in the room. The OIG requested quality reviews and patient safety incident reports related to view alerts and delinquent medical records. Additionally, requests were made for quality reviews specific to the provider. A staff member informed the OIG there were no administrative reviews for the provider, including quality reviews, patient incident reports, or peer reviews. The OIG found no reports of adverse clinical outcomes related to unmanaged view alerts.

The OIG reviewed the facility's View Alert Weekly Tracking report to determine the number of view alerts accumulated by the provider from January 15, 2020, through June 29, 2020. The number of view alerts are tracked on a weekly basis. The provider accumulated 277 alerts during the week of February 10, 2020, and progressively decreased the number to two alerts the week of June 29, 2020. A facility leader informed the OIG that during this time, the provider did not have a full patient panel.

Primary Care Providers' View Alerts

The OIG recognized that high numbers of accumulated view alerts were not isolated to the provider.[23] Facility leaders acknowledged awareness of providers' challenges to manage high numbers of view alerts.

Test results, as well as administrative consults, generate view alerts; therefore, new alerts are created as well as cleared by providers throughout the day.[24] During an interview, the Chief of Staff stated a provider could receive 400 view alerts in one or two days. Facility leaders recognized that view alerts were a time-consuming task for primary care providers, potentially led to missed critical information, reduced time available to see patients, and remained a top reason for provider turnover. To assist providers in managing view alerts, facility leaders formed a Reducing Alert Fatigue Team to implement strategies to reduce the number of unnecessary view alerts providers received, including assisting providers to setup view alert preferences.

Table 1. Primary Care Providers' Accumulated View Alerts

2020	View Alerts
March 10	14,150
March 31	13,766
April 21	10,201
May 11	8,618
June 1	9,200
June 16	9,170

Source: Clinical Applications Coordinator email
Note: The data are examples of weekly facility data reviewed between the time the programmer purged the view alerts and the OIG virtual on-site visit.[25]

Facility leaders and staff attributed some of the reduction of view alerts to the decreased number of appointments secondary to COVID-19 (see table 1). With fewer patients seen, decreased numbers of orders were entered, which reduced the number of new alerts received, and allowed providers additional time to address existing view alerts. The OIG concluded that facility leaders will need to continue to develop and implement strategies to manage view alerts, evaluate the effectiveness, and assess the need for retrospective reviews of patient care.

[23] The OIG reviewed the number of accumulated view alerts for primary care providers from January 15 through June 29, 2020.

[24] VHA Directive 1088; VHA Directive 1232(2).

[25] Because of the volume of view alerts in question, it was impractical for the OIG to evaluate each view alert and the associated EHR documentation individually.

3. Facility Leaders' Response

The OIG determined that facility leaders implemented actions to address the provider's documentation deficiencies. The provider's poor documentation practices were long standing. Facility leaders addressed this issue by instituting several focused professional practice evaluations (FPPEs) for cause for the provider.[26]

VHA requires an ongoing professional practice evaluation (OPPE) for continued monitoring of privileged practitioners to confirm the quality of care delivered.[27] The OIG reviewed the provider's OPPEs that reflected the provider had documentation deficiencies and clinical leaders initiated several FPPEs for cause. The provider's documentation steadily improved during each FPPE. However, the OIG noted a cyclical pattern. After the provider met FPPE expectations and clinical leaders rated the FPPE as successful, the provider reverted to deficient documentation practices.[28]

Facility leaders reported that they provided counseling, sent emails, offered voice recognition and electronic medical record software, and conducted performance evaluations.[29] Facility leaders consulted with Human Resources and the Office of Medical Legal Affairs for guidance on the provider's continued employment. Facility leaders continued to monitor the provider for sustainable compliance with documentation requirements. The Chief of Staff informed the OIG that the provider was no longer treating patients at the facility.

4. Additional Concerns

EHR Review

Despite facility leaders reporting that the provider's delinquent documentation was completed in fall 2019, the OIG determined that 20 of the 220 patient records reviewed did not have an associated progress note for patient care episodes.

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[26] "Provider Competency And Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance," Revision 2, July 2016. VHA Medical Staff Affairs, Office of Safety and Risk Awareness and Office of Quality and Performance, accessed December 21, 2020, https://vaww.qps.med.va.gov/divisions/qm/msa/Privileging/msaPrivileging.aspx. (This is an internal VA website that is not publicly accessible.) An FPPE for cause is "a time-limited period during which the medical staff leadership assesses the provider's professional performance to determine if any action should be taken on the providers privileges." This is an oversight process used when there are concerns regarding aspects of a provider's care to patients.

[27] VHA Handbook 1100.19.

[28] VHA Handbook 1100.19. An FPPE may be rated successful when providers meet identified criteria, and results are documented in the provider's profile and included in the information presented to clinical leaders when considering recommendations on privileges.

[29] To assist the provider with documentation, clinical leaders issued the provider voice recognition and electronic medical record software for dictation. However, facility leaders reported the software did not pick up the provider's voice accurately and was not effective.

According to VHA policy, chiefs of Health Information Management programs are responsible for records management and EHR reviews to ensure timely, complete, and properly authenticated documentation. Reviews must include monitoring for patient care episodes without an associated progress note. Results of reviews must be reported to the Health Information Management Committee.[30]

The OIG did not find evidence that the facility monitored EHRs for patients' episodes of care without associated progress notes from October 2016 through August 2020. The OIG concluded that if monitoring for patient care episodes without an associated progress note had been performed, the provider's missing documentation, as well as other providers' deficiencies may have been identified sooner.

During an interview with the Chief of Health Information Management, who was hired in January 2020, the OIG learned the position had been vacant for approximately four years. The position was covered by a series of individuals in an acting role, and at times as a collateral duty.

The OIG concluded that the absence of a permanent Chief of Health Information Management for a sustained length of time contributed to facility leaders' failure to focus on monitoring EHRs for patient care episodes without an associated progress note.

Facility Policy

VHA policy requires providers to monitor and respond promptly with appropriate action on view alerts, and facility policy should define the time frame for those actions.[31] The OIG found that the facility did not have the required policy. However, the Chief of Staff reported that clinical leaders reviewed the number of alerts for each provider on a weekly basis, held providers accountable for managing alerts, and planned to implement disciplinary action for providers who accumulated alerts. According to the Chief of Staff, managing view alerts is a basic function of care and consideration is being given to writing a standard operating procedure regarding view alerts to hold both clinical leaders and staff accountable.

[30] VHA Handbook 1907.01.

[31] VHA Handbook 1907.01.

Conclusion

A provider failed to complete EHR documentation, specifically progress notes associated with episodes of patient care, within the time frame set by VHA and facility policies. The OIG's review of the identified patients' care did not find adverse clinical outcomes as a result of the provider's delinquent documentation.

The OIG was unable to determine if patients experienced adverse clinical outcomes resulting from the provider accumulating 4,000 view alerts. The provider addressed the 4,000 view alerts prior to the OIG inspection, and they were completed by fall 2019. Facility leaders stated that they found no adverse clinical outcomes resulting from these view alerts. The OIG was unable to review those view alerts, because once addressed, the notification was no longer active or viewable.

A staff member informed the OIG there were no administrative reviews performed for the provider, including quality reviews, patient incident reports, or peer reviews. The OIG found no reports of adverse clinical outcomes related to unmanaged view alerts. Following the OIG's virtual site visit, the provider had only two view alerts accumulated for the week of June 29, 2020.

The OIG recognized that high numbers of accumulated view alerts were not isolated to the provider. Facility leaders stated that view alerts were a time-consuming task for primary care providers, potentially led to missed critical information, reduced time available to see patients, and were a top reason for provider turnover. Facility leaders formed a Reducing Alert Fatigue Team to implement strategies to reduce the number of unnecessary view alerts that providers received. Facility data showed a reduction of accumulated view alerts from March 2020 to June 2020; however, facility leaders and staff attributed some of the reduction to the decreased number of patients seen secondary to COVID-19. The OIG concluded that facility leaders will need to continue to develop and implement strategies to manage view alerts, evaluate the effectiveness of using view alerts, and assess the need for retrospective reviews of patient care related to accumulated view alerts.

The OIG determined that facility leaders implemented actions to address the provider's documentation deficiencies. The OIG found the provider's poor documentation practices were long standing, and facility leaders addressed this issue by instituting several FPPEs for cause. Clinical leaders reported they furnished additional measures to assist the provider with meeting documentation requirements. The OIG noted a cyclical pattern—after the provider successfully met FPPE expectations and clinical leaders rated the FPPE successful, the provider reverted to deficient documentation practices. Facility leaders continued to monitor the provider for sustainable compliance with documentation requirements. The Chief of Staff informed the OIG that the provider was no longer treating patients at the facility.

The Chief of Health Information Management failed to monitor facility EHRs for patient care episodes without an associated progress note as required by VHA policy. However, the OIG was informed that the Chief of Health Information Management was hired in January 2020. Previously the position had been covered by a series of individuals in an acting role. The OIG concluded that the absence of a permanent Chief for a sustained length of time contributed to facility leaders' failure to focus on monitoring EHRs for patient care episodes without an associated progress note.

The OIG found that the facility did not have a policy that defined the time frame providers must monitor, respond, and take action on view alerts, as required by VHA.

Recommendations 1–3

1. The Charlie Norwood VA Medical Center Director confirms that the Chief of the Health Information Management program monitors documentation to include patient care episodes without an associated progress note as part of the ongoing electronic health record review process, and takes action as warranted.

2. The Charlie Norwood VA Medical Center Director ensures a policy defines the required time frame for providers to respond to view alerts.

3. The Charlie Norwood VA Medical Center Director continues to monitor providers' compliance with responding to view alerts, evaluates the effectiveness of the implemented strategies to reduce unnecessary view alerts, and assesses the need for retrospective reviews of patient care related to accumulated view alerts.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 14, 2021

From: Interim Director, Southeast Network (10N7)

Subj: Healthcare Inspection—Failure of a Primary Care Provider to Complete Electronic Health Record Documentation and Inadequate Oversight at the Charlie Norwood VA Medical Center in Augusta, Georgia

To: Director, Office of Healthcare Inspections (54HL06)
Director, GAO/OIG Accountability Liaison (VHA 10B GOAL Action)

1. I have had the opportunity to review the Draft Report: Failure of a Primary Care Provider to Complete Electronic Health Record Documentation and Inadequate Oversight at the Charlie Norwood VA Medical Center in Augusta, Georgia.

2. I concur with Charlie Norwood VA Medical Center's action plan and ongoing implementation for recommendation 1 and request for closure of recommendations 2 and 3.

3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.

4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer.

(*Original signed by*:)

Joe D. Battle

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 11, 2021

From: Director, Charlie Norwood VA Medical Center (509/00)

Subj: Healthcare Inspection—Failure of a Primary Care Provider to Complete Electronic Health Record Documentation and Inadequate Oversight at the Charlie Norwood VA Medical Center in Augusta, Georgia

To: Director, Southeast Network (10N7)

1. We at Charlie Norwood VA Medical Center thank the Office of Inspector General for evaluating and providing recommendations to strengthen our process for Provider Electronic Health Record documentation oversight. At the direction of the leadership our Compliance Officer solicited the OIG's partnership in evaluating the corrective actions already in place and to provide additional recommendations. Their thorough investigation confirmed my concerns and I concur with the recommendations.

2. Charlie Norwood VA Medical Center hereby submits the attached status update providing justification and documentation for the closure of two of the recommendations and a pro-active action plan to complete and achieve closure of the third in six months.

3. If you have any questions or require further information, contact the Acting Chief of Quality Management.

(*Original signed by*:)

Robin E. Jackson, PhD
Medical Center Director

Facility Director Response

Recommendation 1

The Charlie Norwood VA Medical Center Director confirms that the Chief of the Health Information Management program monitors documentation to include patient care episodes without an associated progress note as part of the ongoing electronic health record review process, and takes action as warranted.

Concur.

Target date for completion: September 30, 2021

Director Comments

Charlie Norwood VA Medical Center Chief of Health Administrative Service (HAS) in collaboration with the Chief of HIMS [Health Information Management] conducted a full review of the EHR process (to include documentation related patient care episodes without an associated progress note). As a result, an action plan was developed to address opportunities for improvements. The charter of the CNVAMC [Charlie Norwood VA Medical Center] Medical Records Committee (which is equivalent to a Health Information Management Committee referenced in this OIG report) was updated on March 19, 2021 to ensure it included the encounter review process and mandates monthly reporting and updates to monitor progress and status.

Action Plan

The Chief of HIMS will conduct monthly reviews of all current encounters without associated progress notes. Additionally, the encounter review process will be classified as Standard Work and Standard Operating Procedures (SOPs) will be prepared to ensure sustainment of this critical process.

Monitoring

Starting May 17, 2021, the HIMS coders will conduct monthly reviews (12% of pending backlog plus new encounters identified for evidence of progress notes). Outliers will be communicated in writing with read receipt to appropriate Service Chiefs for their immediate action.

Recommendation 2

The Charlie Norwood VA Medical Center Director ensures a policy defines the required time frame for providers to respond to view alerts.

Concur.

Target date for completion: Completed

Director Comments

Action completed: Charlie Norwood VA Medical Center View Alert Management Standard Operating Policy (SOP) 6103.509, was signed and distributed on November 9, 2020. This policy establishes the timeframe for providers to respond to view alerts. All alerts will be processed within seven days; however, due to its high priority and potential adverse impact, critical alerts must be processed within three days.

OIG Comment

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

Recommendation 3

The Charlie Norwood VA Medical Center Director continues to monitor providers' compliance with responding to view alerts, evaluates the effectiveness of the implemented strategies to reduce unnecessary view alerts, and assesses the need for retrospective reviews of patient care related to accumulated view alerts.

Concur.

Target date for completion: Completed

Director Comments

Action completed: The Medical Center Director has an established process for continuous monitoring of provider compliance with timely response to view alerts.

Action Plan: Three Chief of Staff administrative personnel were trained to ensure alerts are monitored and sent out a weekly to Service/Department Chiefs. Service/Department Chiefs subsequently review the Alert Report and resolving any unreconciled alerts in accordance with SOP 6103.590, with special attention to those providers with a view alert volume greater than 300 view alerts, view alerts over seven days, and critical alerts over three days.

The Chief Health Informatics Officer collaborated with Clinical Application Coordinators and Service/Department Chiefs weekly reviewing all alert teams, flagged orderable items, and ensuring consult notifications are set up and managed properly. Consistent with the tenets of a Just Culture, CNVAMC will review Providers who fail to address alerts timely on more than two occasions. Additionally, when appropriate an FPPE for Cause will be instituted to improve and to sustain the performance of the Provider.

Audit: After achieving four months of data, we have significant improvements in the View Alerts process. Charlie Norwood VA Medical Center will continue its ongoing professional

practice evaluation (OPPE) for continued monitoring of privileged practitioners to confirm the quality of care delivered.

Table 1. Primary Care Providers' Accumulated View Alerts 2/11/2021 thru 5/6/20

Date	Total Alerts	Critical Alerts
2/11/2021	**62,091**	**2888**
3/17/2021	**58,653**	**2184**
4/28/2021	**53,193**	**1319**
5/6/2021	**46,609**	**1455**

Source: Clinical Applications Coordinator

OIG Comment

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

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