

## United States Senate

WASHINGTON, DC 20510

COMMITTEES:  
APPROPRIATIONS  
COMMERCE  
HEALTH, EDUCATION,  
LABOR, AND PENSIONS

April 30, 2020

Richard A. Stone, M.D.  
Executive in Charge  
Veterans Health Administration  
U.S. Department of Veterans Affairs  
810 Vermont Avenue, NW  
Washington, DC 20420

Victoria P. Brahm  
Director  
VISN 12  
U.S. Department of Veterans Affairs  
4 Westbrook Corporate Center  
Westchester, Illinois 60154

Daniel S. Zomchek  
Director  
Milwaukee VA Medical Center  
U.S. Department of Veterans Affairs  
5000 W National Ave  
Milwaukee, WI 53295

Dear Dr. Stone and Directors Brahm and Zomchek,

In response to the VA Office of Inspector General (OIG) April 29, 2020 report entitled, *Manipulation of Radiology Reports and Leadership Failures in the Medical Imaging Service at the Clement J. Zablocki VA Medical Center*, I write to request the full implementation of recommendations made by the OIG and to be kept informed as to the progress made in meeting those quality improvement benchmarks.

It is my understanding that following the receipt of an anonymous complaint in August 2018, the VA OIG initiated an investigation that ultimately culminated in the April 29, 2020 report. The complaint alleged that a Zablocki VAMC radiologist made gross errors that resulted in treatment delays, placed misleading addenda in two patients Electronic Health Record (EHR), and that leadership was tolerant of this practice.

The report found concerning manipulation and vulnerability of the EHR. Specifically, that certain facility personnel had the ability to un-verify a report and add, change, or delete information from the EHR. Further, OIG found that management took advantage of that ability and ordered manipulation of the EHR. In addition, the report found that interpersonal conflicts went unaddressed creating a hostile work environment and potentially negatively impacting patient care. Staff radiologists reported to OIG that they felt pressure to comply with instruction to add addenda they did not agree with. And, Medical Imaging Service staff had among the lowest All Employee Survey scores at Zablocki.

In response to these findings, the OIG recommends:

1.) VA Under Secretary for Health to:

- a. Ensure that the planning and implementation of the new EHR includes a process for addenda insertion, deletion and consistent formatting for radiology reports. (Target completion date of 11/2020).
- b. Review VHA policy related to management of health information in the electronic health record, evaluates the circumstances that led to the Division Manager's decision to direct the deletion of completed and verified imaging report, and take action, as indicated. (Target completion date of 6/2020).

2.) Zablocki VAMC to:

- a. Ensure a review of the radiology report for the patient with conflicting imaging study results and confirms that the most accurate impression is evident in the EHR. (Target completion date of 3/31/ 2020).
- b. Review the oversight and management of the Medical Imaging Service, confer with HR, make recommendations for improvement and monitor progress. (Target completion date of 4/30/ 2020).
- c. Complete an evaluation of the Medical Imaging Service's culture, morale, and team cohesion, and develop an action plan for improvement. (Target completion date of 6/15/20200.)
- d. Evaluate the need for imaging staff to receive training on workplace intimidation and the process for employee reporting of concerns. (Target completion date of 3/31/2020).

3.) VISN12 to:

- a. Review access, management, and the VISN oversight of Zablocki picture archiving and communication system practices. (Target completion date of 11/30/2020)/
- b. Make certain that future hotline case referrals are investigated in accordance with VA policy related to OIG Hotline complaint referrals. (Target completion date of 3/31/ 2020).

While I am pleased that the report ultimately found no incident of patient harm, it raises larger concerns about vulnerabilities in the VA's EHR system—ones which much be addressed expediently as the Department undergoes its Electronic Health Record Modernization (EHRM). Similar vulnerabilities may be present in the new EHR system and must be addressed prior to the transition to the new system. I appreciate your prompt attention to this report, full implementation of the IG's recommendations and look forward to your response.

Sincerely,

A handwritten signature in blue ink that reads "Tammy Baldwin". The signature is fluid and cursive, with the first name "Tammy" and last name "Baldwin" clearly distinguishable.

Tammy Baldwin  
United States Senator