



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Patient Care, Fraud, and Mismanagement Issues VA Medical Center San Juan, Puerto Rico

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DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA Sunshine Healthcare Network (10N8)

SUBJECT: **Final Report** – Patient Care, Fraud, and Mismanagement Issues, VA Medical Center, San Juan, Puerto Rico, Project No. 2004-02962-HI-0360

Purpose

The VA Office of Inspector General (OIG), Offices of Healthcare Inspections, Audit, and Investigations reviewed multiple allegations made by a former employee of the VA Medical Center, San Juan, Puerto Rico. The purpose of the review was to determine whether the allegations had merit.

Background

The VA Medical Center located in San Juan, Puerto Rico, is a 348-bed tertiary care hospital that provides a broad range of inpatient and outpatient health care services. The medical center is part of Veterans Integrated Service Network (VISN) 8.

The complainant, a former VA pathologist, made multiple allegations to the news media related to quality and timeliness of patient care, fraud, and mismanagement at the medical center. Articles and editorials, which identified the complainant by name, appeared in *El Nuevo Dia* and *El Vocero* newspapers from July 7-20, 2004. The complainant alleged that:

- Medico-legal death cases are not referred to Puerto Rico law enforcement authorities (Forensic Science Institute).
- Autopsies are not consistently requested as required by policy.
- A sentinel event involving depletion of the facility's bulk oxygen supply was not reported to appropriate authorities.
- A patient died because surgeons did not treat his clogged carotid arteries while performing a coronary artery bypass graft (CABG), and his autopsy findings were falsified to avoid a malpractice suit.

- A patient's autopsy findings did not include peritonitis as a cause of death, even though the patient had an infection resulting from a surgical towel left in his abdomen.
- Medical center staff cancelled consultation requests without prior notification to the patients' primary care providers.
- Part-time (PT) attending physicians do not work their scheduled hours, and residents do not receive appropriate supervision.
- Increased physician workload has prolonged patient waiting times.
- Medical center managers did not correct deficiencies identified during an OIG Combined Assessment Program (CAP) review in January 2001.¹

Scope and Methodology

We visited the facility November 15-18, 2004, and reviewed medical records, pertinent facility policies, newspaper articles, appointment scheduling and waiting time data, time and attendance reports, desk audit documents, and physician conflict of interest statements. We interviewed the Forensic Science Institute (FSI) Executive Director, medical center managers and service chiefs, the medical center Quality Manager, and facility employees directly involved with, or knowledgeable about, the complainant's allegations. We interviewed the complainant three times to better understand his concerns. The allegation that medical center managers did not correct deficiencies identified in our 2001 CAP review was addressed during a subsequent CAP review in April 2005.

We performed the inspection in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Results

Issue 1: Medico-Legal and Autopsy Case Referrals

Allegation A. Medico-legal death cases are not referred to Puerto Rico law enforcement authorities.

We substantiated the allegation that medico-legal death cases are not consistently reported to Puerto Rico law enforcement authorities as required. VA Manual M-2, Part VI, Chapter 9, "Post-Mortem Examination," states that certain deaths that occur in a VA medical center may be of potential medico-legal significance. These deaths must be reported to a local investigatory agency in accordance with federal requirements. The VA Manual identifies 8 circumstances under which reporting is mandatory; the medical

¹ OIG Report Number 02-00868-15, *Combined Assessment Program Review of the VA Medical Center, San Juan, Puerto Rico*, November 13, 2002.

center’s policy (Medical Center Memorandum [MCM] 136-04-01, May 2004) is more expansive and includes 21 different circumstances when VA staff should report deaths to law enforcement authorities.

FSI is the primary investigative authority on the island of Puerto Rico, and periodically conducts autopsies on cases referred by VA. From January 1, 2003, to June 30, 2004, FSI accepted 52 cases referred by designated VA employees for post-mortem examinations. To establish whether additional death cases should have been referred, we evaluated Morbidity and Mortality (M&M) reviews² and occurrence screens for deaths that occurred during the same time period. M&M reviews are usually conducted in cases that were controversial or difficult, clinical findings were interesting or unexpected, or in which there were significant differences between the premortem diagnosis and the pathological findings. Occurrence screens identify cases where death occurred within 24 hours of hospital admission, or 24 hours after a surgical procedure. We found at least 51 additional cases that met criteria for reporting to law enforcement authorities; however, we could only find documentation that 8 cases were reported, as required.

Reporting Criteria (MCM 136-04-01)	Reportable Cases	Actual Cases Reported
Death occurred during or after ³ surgical, diagnostic, or therapeutic procedures	2	0
Death within 24 hours of hospital admission	40	6
Death due to known or suspected therapeutic misadventure	3	0
Death due to a suspected accident or act of violence	4	0
Death due to suspected negligence	2	2
Total Cases	51	8

The medical center did not have a systematic process for identifying and referring cases to FSI. One interviewee told us that the primary provider identified cases for referral to FSI, while another interviewee told us that pathologists determined which cases should be referred. Additionally, it appeared that pathologists, the Death Details Clerk, and the medical center Administrative Officer of the Day all have authority to refer cases to FSI, but we found no documented procedures to ensure that cases were appropriately referred.

Medical center managers told us that upon notification of a potential medico-legal death case, FSI officials often decline the case due to their own workload demands. FSI may then designate or permit VA to perform the autopsy. The FSI Executive Director confirmed this system of case reporting, and told us that VA appropriately refers cases to his department. This is an acceptable practice that meets the intent of the policy; however, the notification and FSI declination of the case should be documented.

² Medical and Surgical Service Morbidity and Mortality reviews.

³ VA Manual M-2, Part VI, Chapter 9 defines this criterion as death occurring with 24 hours after an invasive diagnostic or therapeutic procedure.

Conclusion

Medical center managers did not have established procedures to ensure that cases of potential medico-legal significance were consistently identified and referred to law enforcement authorities, or that referrals were properly documented. Without these procedures, managers could not assure compliance with VA and medical center policies related to medico-legal cases.

Recommended Improvement Action(s) 1. The VISN Director needs to ensure that the Medical Center Director requires that:

- a. Cases of potential medico-legal significance are appropriately identified and referred to appropriate law enforcement authorities.
- b. Authorized employees document referrals to law enforcement authorities and their ultimate disposition.

VISN and Medical Center Directors' Comments

The VISN and Medical Center Directors agreed with the findings and recommendations, and the VISN Director concurred with the Medical Center Director's corrective action plans. The Medical Center Director initiated a workgroup to review Puerto Rico laws regarding the reporting of medico-legal death cases and the requirements for autopsies. A revised medical center policy is in the concurrence process.

Assistant Inspectors General Comments

The VISN and Medical Center Directors agreed with the findings and recommendations, and provided acceptable improvement plans. We will follow up on planned actions until they are complete.

Allegation B. Autopsies are not requested per policy.

We substantiated the allegation that autopsies were not consistently requested on all patients who died while hospitalized or in a VA nursing home. According to Veterans Health Administration (VHA) policy and the medical staff by-laws, permission to perform an autopsy shall be sought in every instance that a patient dies while an inpatient at a VHA facility or under the immediate care of a VHA facility, including veterans who are in a VA Nursing Home Care Unit. We reviewed a random sample of 30 death cases occurring between January 1, 2003, and June 30, 2004, and found that in 20 (67 percent) cases, providers had documented requests for autopsies and the dispositions of those requests. In 9 of the 10 remaining cases, the medical record reflected that, "An autopsy will be offered," but there was no further documentation concerning the outcomes of these apparent requests. In the last case, the provider documented that an autopsy would not be requested.

We learned that the medical center had implemented a new system to promote autopsy requests. The Chief of Staff is notified whenever a patient died but an autopsy was not requested, or the autopsy request was not documented in the medical record. The Chief of Staff forwards a memorandum to the provider as a reminder of the need to request and document autopsy discussions with patients' families. Because the medical center had addressed this issue, we did not make a recommendation.

Allegation C. A patient's death after a bulk oxygen system failure was not reported to appropriate authorities in accordance with established policy, and medical center staff inappropriately performed the patient's autopsy.

We did not substantiate the allegation that medical center managers did not follow protocol in reporting the death of a patient who died after a bulk oxygen system failure, nor did we substantiate the allegation that the medical center improperly performed the patient's autopsy.

The patient was an 81-year-old ventilator dependent male admitted to the medical center on February 18, 2004, for jaundice. The patient had a primary medical history that included bladder cancer, gallstones, diabetes, hypertension, and coronary artery disease, and he had been bedridden for 4 years prior to his admission. The patient had a poor prognosis, and a "Do Not Attempt Resuscitation" order was written on February 25. The patient died March 17, within hours of the failure of the medical center's bulk oxygen utility system.

VA policy specifically defines the circumstances under which deaths must be reported to authorities. VA Handbook 1106.1, "Post Mortem Examinations," (June 2003) references 38 CFR § 17.170(c), which reads as follows:

"If it is suspected that death resulted from crime and if the United States has jurisdiction over the area where the body is found, the Director of the Department of Veterans Affairs facility will inform the Office of Inspector General of the known facts concerning the death. Thereupon the Office of Inspector General will transmit all such information to the United States Attorney for such action as may be deemed appropriate and will inquire whether the United States Attorney objects to an autopsy if otherwise it be appropriate. If the United States Attorney has no objection, the procedure as to autopsy will be the same as if the death had not been reported to him or her."

Documentation and interviews established that within 4 hours of the incident, medical center managers had notified VISN officials and Regional Counsel representatives of the patient's death. Managers were only required to formally notify the OIG of the patient's death if they believed that a crime (or possible crime) occurred. We found no evidence to suggest that the medical center's top managers thought the bulk oxygen system failure was an intentional act to harm patients or sabotage facility operations.

The Chief of Laboratory and Pathology Service notified FSI as required, and by mutual agreement, VA pathologists conducted the patient's autopsy. The pathologist concluded that:

“This patient was being treated for multiple system insufficiency as described in the final clinical summary. His final mode of exit was due to heart failure complicated with severe pneumonia and pulmonary inability to oxygenate blood. A probable dysfunction of the external oxygen supply is mentioned but this would not have contributed to the pulmonary failure to utilize oxygen.”

The medical center conducted a thorough Root Cause Analysis and made appropriate changes to its Bulk Oxygen Utility Program. A detailed report of the oxygen system failure investigation will be published under separate cover.

Issue 2. Patient Treatment and Autopsy Findings

Allegation D. A patient died because surgeons did not treat his clogged carotid arteries while performing a CABG, and his autopsy findings were falsified to avoid a malpractice suit.

We did not substantiate the allegation that surgeons did not appropriately treat a patient's clogged carotid arteries while performing a CABG. The patient was a 75-year-old male with a history of coronary artery disease who needed triple-bypass surgery. On May 9, 2003, he underwent a magnetic resonance angiogram of the neck to determine the extent of his carotid occlusions; the radiologist found 25 and 60 percent stenosis (narrowing) of the right and left internal carotid arteries, respectively. Also on May 9, the patient was evaluated by a vascular surgeon, who determined that since the patient was asymptomatic, and had never had a stroke or other neurological occurrences, there was no indication for a carotid endarterectomy (surgical removal of arterial plaque). Surgeons completed an appropriate work-up for the CABG including laboratory studies, radiology examinations, an echogram, and a cardiac catheterization. The patient underwent open-heart surgery on May 19.

The patient experienced a complex post-operative course, which included confusion and agitation, pneumonia, two episodes of acute respiratory failure requiring intubation and breathing assistance, dehydration, and acute renal failure. He was treated with antibiotic therapy and hemodialysis. He received a gastrostomy tube for feeding, as well as daily laboratory studies and chest x-rays. Despite aggressive treatment, the patient's condition continued to deteriorate and he became increasingly jaundiced. The patient remained in critical condition, but hemodynamically stable, until June 26, when he developed a dangerously slow heart rate and low blood pressure. Arterial blood gas studies revealed severe acidosis (excess acid in the body fluids). Although treated aggressively according to the advanced cardiac life support protocol (a code was called and initiated), the patient

died at 12:45 p.m. An autopsy was performed and the cause of death was determined to be multi-organ failure and acute respiratory distress.

We did not substantiate the complainant's allegation that autopsy findings were falsified. Specifically, the complainant alleged that another pathologist switched brain tissue samples with another deceased patient to hide the fact that the subject patient died of a stroke caused by untreated carotid occlusions. A neuropathologist reviewed the brain descriptions and histological slides for both autopsies, and determined that neither patient died of a stroke secondary to occlusion of the internal carotid arteries. Overall, there was no evidence – clinical or pathological – that any switching of body tissues had occurred. However, the Armed Forces DNA Identification Laboratory in Rockville, Maryland, was unable to complete DNA sequencing and comparison as the patients' tissue samples were insufficient for testing purposes.

Allegation E. A patient's autopsy findings did not include peritonitis as a cause of death, even though the patient had an infection resulting from a surgical towel left in his abdomen.

We did not substantiate the allegation that a pathologist failed to document peritonitis as a cause of a patient's death. The 71-year-old male had a history of chronic obstructive pulmonary disease, high blood pressure, and obstructive colon cancer with metastasis to the liver. On May 25, 2001, he underwent a proctectomy and colostomy at the medical center. Post-operatively, the patient developed abdominal distention and an infection that did not respond to medical management. A May 30 computerized tomography scan revealed that the patient had a complete bowel obstruction. He was returned to the operating room, where a surgical towel was removed from his abdomen. The patient's condition improved, his temperature returned to normal, and he was started on a clear liquid diet. On June 5 he developed severe respiratory distress, swollen legs, and an electrolyte imbalance. The patient was transferred to the Surgical Intensive Care Unit. On June 6 he suffered a cardiac arrest and died later that day.

The complainant alleged that the veteran died, in part, because of peritonitis caused by the surgical towel. The medical record documentation does not support this assertion. The patient did not show signs of infection (either fevers or elevated white blood counts) after removal of the towel. The patient's complex medical condition, including complete occlusion of the common iliac arteries (arteries to the legs), and the length of time he was bedridden, increased the potential for a thrombus (blood clot) to develop in his legs. The final autopsy diagnoses of metastatic colon cancer and pulmonary thromboembolism were consistent with the patient's medical history.

The medical center conducted a thorough Root Cause Analysis of the incident and took appropriate corrective actions.

Issue 3: Mismanagement

Allegation F. Managers cancelled consultation requests without prior notification to the patients' primary care providers.

We substantiated the allegation that medical center staff cancelled consultation requests prior to notifying the patients' primary care providers (PCPs). During FY 2004, the medical center staff cancelled 1,519 consultation requests prior to notifying the patients' PCPs. After the consultation requests were cancelled, a "VA alert" was placed in the electronic medical record (EMR) system advising the PCPs to review the medical records to determine if consultations were still needed, and to issue new consultation requests, if necessary.

According to the medical center Chief of Health Benefits Administration Service (HBAS), as of March 2004, there were 48,688 open consultations that had been electronically requested through EMR during FYs 2002-2004, but not closed. The Chief of HBAS told us that the consultations were not completed because the medical center implemented EMR incrementally, and staff lacked the knowledge and training needed to enter corresponding actions in EMR to complete the open consultation requests.

The medical center "quadrad"⁴ decided to close pending consultations in order to comply with VHA Directive 2003-068, "Process for Managing Patients When Patient Demand Exceeds Current Clinical Capacity," that required VA medical facilities to schedule all appointment requests including consultation requests with specialists within 7 business days, or place the patient on a wait list. During March 2004, the medical center initiated a process to review and close backlogged consultation requests in an effort to comply with this VHA directive. The Chief of HBAS instructed medical center staff to:

- Link "progress notes" in EMR to the consultation requests in all cases where specialists entered a "progress note" to document the consultation rather than entering their findings on the consultation request form (28,187 consultation requests).
- Schedule clinic appointments for patients with consultation requests that were accepted by the specialty services but not scheduled or placed on a waiting list (6,581 consultation requests).
- Discontinue duplicate consultation requests and diagnostic tests (i.e., electrocardiograms) inappropriately entered as consultation requests in EMR (12,401 consultation requests).

⁴ The "quadrad" consists of the Medical Center Director, Associate Director, Chief of Staff, and Chief Nurse Executive.

- Cancel consultation requests where there was no evidence in EMR that the patients were seen by specialists and alert the PCPs to re-request consultations, if necessary (1,519 consultation requests).

After the consultations were closed, the PCPs received “VA alerts” in EMR identifying the actions taken by medical center staff.

Even though the PCPs were alerted, HBAS did not track or monitor actions taken by the PCPs on the 1,519 consultation requests that were cancelled. Therefore, the medical center had no assurance that patients requiring consultations by specialists were seen after their consultation requests were cancelled.

The Acting Chief of Ambulatory Care (ACAC) stated she reviewed “VA alerts” on her patients resulting from the backlogged consultation requests to determine if consultations were still needed. The ACAC stated that in many instances no actions were necessary because the specialists had seen the patients prior to the consultation requests being closed. However, the specialists did not always link their progress notes to the consultation requests in EMR after evaluating patients.

Presently, HBAS monitors consultation requests by clinical service to ensure that consultation requests are scheduled or patients are placed on a wait list within 7 business days, and certifies quarterly to the VISN that the medical center is in compliance with VHA Directive 2003-068.

Conclusion

We substantiated the allegation that medical center staff cancelled consultation requests prior to notifying the patients’ PCPs. The medical center staff closed 48,688 consultation requests, including canceling 1,519 requests prior to notifying the patients’ PCPs. While some actions were taken on consultation requests by HBAS to minimize future backlogs, further actions were needed to ensure that all patients that had consultations cancelled either received, or will receive, the proper medical attention.

Recommended Improvement Action(s) 2. The VISN Director should ensure that the Medical Center Director requires that:

- a. PCPs review the medical records, reschedule consultations with specialists if necessary, and document their decisions in the patients’ medical records for the 1,519 patients that had consultation requests cancelled.
- b. All staff involved in the consultation process are trained in the use of EMR, specifically the consultation tracking system.

VISN and Medical Center Directors' Comments

The VISN and Medical Center Directors agreed with the findings and recommendations, and the VISN Director concurred with the Medical Center Director's corrective action plans. Clinical service chiefs reviewed the 1,519 consults and took action to address consults when indicated. Administrative employees (301) were trained in the proper use of the consult and scheduling packages, the electronic waiting list, and Access to Care monitors. Physicians (195) received training in consult management and documentation.

Assistant Inspectors General Comments

The VISN and Medical Center Directors agreed with the findings and recommendations, and provided acceptable improvement plans. We will follow up on planned actions until they are complete.

Allegation G. PT physicians in Surgical Service were not complying with their assigned tours of duty, residents were not properly supervised, and residents were apprehensive about contacting attending physicians for fear of not having their terms of residency re-approved. As a result, autopsies showed substandard care had been provided to patients.

We did not substantiate the allegation that PT physicians in Surgical Service were not complying with their assigned tours of duty, residents were not properly supervised and fearful of contacting attending physicians, or that autopsies showed substandard care had been provided to patients. We conducted a roll call of 10 of 15 (67 percent) PT physicians that had tours of duty on November 17, 2004, and found that all were present as required, or were on approved leave. The Chief of Staff, Chief of Surgical Service, and the Compliance Officer were not aware of any instances where PT physicians failed to meet their tours of duty obligations.

However, our review of "Subsidiary Time and Attendance Reports" (VA Form 4-5631a) for 30 of the 33 PT physicians in Surgical Service during pay period 22 (October 31, 2004, to November 13, 2004) showed that 20 of the 60 (33 percent) reports were incomplete. We found that 7 reports showed that PT physicians did not post their time and attendance data daily and 10 reports showed that PT physicians did not certify the hours they worked at the end of the pay period as required by VA Handbook 500, Part II, Chapter III. Additionally, all 20 reports reviewed showed that the subsidiary records did not contain the timekeeper or the approving official signatures. Three of the 33 PT physicians did not submit VA Form 4-5631a. We also reviewed the medical center's "Monthly Time and Attendance PT Physicians Compliance Audit Reports" for October 2003 and October 2004. The compliance audits showed that PT physicians were present in the medical center or performing VA work during core hours. However, the audits showed 12 of the 34 (35 percent) PT physicians did not post and sign their subsidiary

records timely. VA policy requires physicians to provide Form 4-5631a to the timekeeper no later than 9:00 a.m. on Monday following the close of the biweekly pay period.

We interviewed 5 of 20 (25 percent) residents in Surgical Service and found that residents were not fearful about contacting physicians with patient care issues or problems and felt that they were properly supervised. The Chief of Staff, Chief of Surgical Service, and the Compliance Officer, were not aware of any instances where residents provided substandard care due to lack of supervision.

Since the complainant did not provide specific cases for review and autopsy reports do not attribute causes of death to physicians, we reviewed 18-months of “Morbidity & Mortality Reports” for the period January 2003 through July 2004 for Medical and Surgical services. The review found no evidence to suggest that attending physicians attributed complications or poor patient outcomes to substandard care provided by residents. Therefore, we concluded that the allegations were not substantiated.

Conclusion

We did not substantiate the allegation that PT physicians in Surgical Service were not complying with their assigned tours of duty, residents were not properly supervised and fearful of contacting attending physicians, or autopsies showed substandard care had been provided to patients. However, we did find that subsidiary time and attendance reports were not always completed.

Recommended Improvement Action(s) 3. The Medical Center Director needs to ensure that:

- a. “Subsidiary Time and Attendance Reports – Part Time Physicians” are completed by all PT physicians and submitted to the unit timekeepers no later than 9:00 a.m. on Monday following the close of the biweekly pay period.
- b. Timekeepers and approving officials sign the “Subsidiary Time and Attendance Reports – Part Time Physicians.”

VISN and Medical Center Directors’ Comments

The VISN and Medical Center Directors agreed with the findings and recommendations, and the VISN Director concurred with the Medical Center Director’s corrective action plans. Facility managers provided appropriate training, and conducted physical and electronic verification of PT physicians’ time and attendance.

Assistant Inspectors General Comments

The VISN and Medical Center Directors agreed with the findings and recommendations, and provided acceptable improvement plans. We will follow up on planned actions until they are complete.

Allegation H. Increased physician responsibility for performing clerical work had the effect of prolonging clinic appointment times to over 30 minutes per patient, which lengthened the waiting times of hundreds of patients.

We did not substantiate the allegation that increased physician responsibility for performing clerical work had the effect of prolonging clinic appointment times to over 30 minutes per patient, and lengthening the waiting times of hundreds of patients. The alleged increase in clerical work was related to a new requirement that physicians document patient encounters in EMR.

VHA policy requires that workload data must be captured through electronic means and physicians must use direct order entry into EMR. During FY 2004, the Chief of Staff instructed physicians to document all patient encounters in EMR. The medical center policy is to schedule patients in 30-minute slots as part of their scheduling package. VHA policy does not require the medical center to have a mechanism in place to track the actual time a physician spends with a patient, including documenting patient encounters in EMR. According to medical center reviews, the facility met VHA timeliness goals for wait times. VHA national timeliness goals for FY 2004 required that 70 percent of patients be seen by a provider within 20 minutes of their scheduled appointment. Cycle time studies performed by the medical center to monitor wait times in primary care clinics during the period January to June 2004 showed that 571 of 746 (77 percent) patients surveyed stated they were seen within 20 minutes of their scheduled appointments.

Conclusion

We did not substantiate the allegation that increased physician workload prolonged patient waiting times. The medical center met the VHA national timeliness goal that requires 70 percent of all patients be seen by a provider within 20 minutes of their scheduled appointment times.

(original signed by:)

JOHN D. DAIGH, Jr., MD
Assistant Inspector General
for Healthcare Inspections

(original signed by:)

MICHAEL L. STALEY
Assistant Inspector General
for Auditing

VISN 8 Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: May 23, 2005

From: Director, VA Sunshine Healthcare Network (10N8)

Subject: **Patient Care, Fraud, and Mismanagement Issues at the VA Medical Center, San Juan, Puerto Rico, Project No. 2004-02962-HI-0360**

To: Assistant Inspector General for Healthcare Inspections

1. Thank you for the opportunity to review the draft report of the Patient Care, Fraud and Mismanagement Issues at the VA Medical Center, San Juan, Puerto Rico, Project No. 2004-02962-HI-0360.

2. We have read the report and we concur with the Office of Inspector General for Healthcare Inspections findings and we agree with the actions taken by the San Juan VAMC.

3. Please contact Ms. Karen Maudlin at (727) 319-1063 if you have any questions.

(original signed by:)

George H. Gray, Jr.

Network Director, VISN 8

Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: May 20, 2005
From: Medical Center Director (672/00)
Subject: **Patient Care, Fraud, and Mismanagement Issues at the
VA Medical Center, San Juan, Puerto Rico, Project No.
2004-02962-HI-0360**
To:

I take this opportunity to thank you for allowing me the opportunity to review and respond to the subject report. I concur with the conclusions presented by the Office of the Inspector General in which all allegations of misconduct and unethical behavior were not sustained.

I also concur with the three (3) recommended improvement actions related to administrative procedures and present evidence that describes the actions we have taken to enhance such processes.

(original signed by:)

Rafael E. Ramirez, MD, FACP

Medical Center Director

**Director's Comments
to Office of Inspector General's Report**

The following Director's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

OIG Recommendation(s)

Recommended Improvement Action(s) 1. The VISN Director needs to ensure that the Medical Center Director requires that:

- a. Cases of potential medico-legal significance are appropriately identified and referred to appropriate law enforcement authorities.
- b. Authorized employees document referrals to law enforcement authorities and their ultimate disposition.

Concur **Target Completion Date:** June 30, 2005

Actions Taken 1(a): A workgroup comprised of the Quality Manager, Chief Medical Service, Pathologist, Surgical Service Representative, Details Clerk Supervisor, and Regional Counsel, was launched to revise Center Memorandum 136-04-01, May 2004. The group was charged to review the Puerto Rico State Laws in relation to medico-legal deaths and requirements for autopsy. The draft memo was presented for concurrence to the Chief Medical Service Representative, Chief Surgical Service, Chief SCI and Pathologist. The San Juan VA Medical Center Chief of Staff and the Regional Counsel are in the process of clarifying criteria within the PR Law to ascertain compliance with it.

Upon clarification, the revised Center Memo will be submitted to the San Juan VA Medical Center Director for approval. Publication and implementation will follow.

Action taken 1(b): The same workgroup reviewed the existing process and performed a gap analysis. A new flow chart was designed to delineate clearly the steps to be followed when requesting an autopsy in addition to identifying medico-legal cases. The new flow chart also identifies who is responsible for reporting deaths to law enforcement authorities. All documentation will be evidenced in the CPRS in lieu of maintaining a log book at the Pathology Service. The new flow chart will be included in the revised center memorandum.

Recommended Improvement Action(s) 2. The VISN Director should ensure that the Medical Center Director requires that:

- a. PCPs review the medical records, reschedule consultations with specialists if necessary, and document their decisions in the patients' medical records for the 1,519 patients that had consultation requests cancelled.
- b. All staff involved in the consultation process are trained in the use of EMR, specifically the consultation tracking system.

Concur **Target Completion Date:** May 20, 2005

Actions Taken 2(a): The 1,519 consults were identified by IRM. An excel sheet was provided to Clinical Service Chief's for review and appropriate action. The following dispositions were obtained and any necessary follow up has been completed.

- § No clinical criteria's for consult
- § Duplicate consults
- § Patients already seen
- § Wrong service consulted
- § Patient died prior to the appointment

§ Patient discharged from clinic due to No Show

Actions Taken 2(b): The training “ACCESS TO CARE” was provided to 301 administrative employees from the San Juan facility as well as the remote Out Patient Clinics. The objective was to ensure compliance with access to care initiatives for the consult and scheduling packages, the electronic waiting list and monitors. The content of the training included the following:

§ PURPOSE OF TRAINING

§ TRAINING OBJECTIVES

§ IMPORTANCE OF TIMELY ACCESS AND DATA INTEGRITY

§ REQUEST FOR HEALTHCARE

§ PATIENT TYPE DEFINITIONS

§ CONSULTS

§ CONSULT TRACKING

§ CONSULT – CPRS STATUS

§ CONSULT PROCESSING

§ WAITING TIME IMPACT

§ SCHEDULING CRITERIA

§ SCHEDULING PRIORITIES

§ YOUR IMPORTANT ROLE...

§ “DESIRED DATE”

§ APPOINTMENT TYPES

§ SCHEDULING APPOINTMENT TIP

- § CANCELLATIONS
- § CORRECTING DATE ERRORS
- § CORRECTING OTHER ERRORS
- § REVIEW OF DIRECTIVES
- § THE ELECTRONIC WAIT LIST
- § MANAGING PATIENTS ON THE EWL
- § EWL MENU OPTIONS
- § MONITORING ACCESS TO CARE
- § WORKING KNOWLEDGE
- § QUESTIONS?

The training “Consult Management” was provided to 195 physicians from the specialty clinics including the San Juan facility as well as the remote Out Patient Clinics. The content of the training included the following:

- § CONSULT – CPRS STATUS
- § CONSULT PROCESSING
- § SCHEDULING CRITERIA
- § REVIEW OF DIRECTIVES
- § SCHEDULING PRIORITIES
- § “DESIRED DATE”
- § ATTACH YOUR NOTE TO THE CONSULT

All 496 participants were entered into the TEMPO system.

Recommended Improvement Action(s) 3. The Medical Center Director needs to ensure that:

- a. “Subsidiary Time and Attendance Reports – Part Time Physicians” are completed by all PT physicians and submitted to the unit timekeepers no later than 9:00 a.m. on Monday following the close of the biweekly pay period.
- b. Timekeepers and approving officials sign the “Subsidiary Time and Attendance Reports – Part Time Physicians.”

Concur **Target Completion Date:** April 18, 2005

Actions Taken 3a&b:

The following actions were taken after the November 15-18, 2004 OIG site visit:

§ Timekeeping Training was provided by Fiscal Service to a total of 33 clinical services timekeepers.

§ Time and Attendance Monitoring Training provided by the Compliance Officer during clinical service meetings including: the ACOS Meeting, Service Chiefs meeting, Clinical Executive Board and Radiology Service.

§ All required documentation including: the Tour of Duty, Memorandum of Understanding, Service Agreements, Certification of Understanding and Conflict of Interest were reviewed January, 2005 through March, 2005 and are on file for all Part Time Physicians.

§ Conducted 100% physical and electronic verification of all Part Time Physicians complied with all reporting requirements to VISN 8.

§ The Compliance Officer met with Chief of Staff to discuss Time and Attendance policies and procedures.

§ The Compliance Officer conducted interviews with all Clinical Service Chiefs to ensure compliance with Part Time Physicians Time and Attendance monitoring and provided

appropriate VHA Directive and Center Memorandum policies.

§ In three occasions Fiscal Service employees audited timekeeper's records and appropriate corrective actions were taken.

The OIG performed a CAP review during the site visit to the San Juan VA Medical Center on April 28-22, 2005. The OIG CAP auditors were provided with the following information on Part-Time physicians prior and during their site visit:

§ Facility policies on time and attendance and timekeeping practices.

§ Excel spreadsheet of all part-time physicians including: name, service, specialty, appointment level (1/8s), VA and non-VA research projects, percentage of time allotted for patient care, administrative duties, research, whether the physician is on an adjustable (A) or fixed (F) schedule, name of the timekeeper, and the time and leave unit. Exclude full-time, contract, fee basis, intermittent, consulting, without compensation (WOC), and resident physicians.

§ VistA printouts of each part-time physician's current 2-week tour of duty schedule.

§ Current Research Project History report. The report includes active, pending, and future projects for facility physicians.

§ List of physician timekeepers, their Service/Department, and contact information.

§ Name of Fiscal Chief or designee and contact information.

§ Desk audit reports for the last 2 years.

§ Computer access to the PAID menu in VistA

§ Part Time Physicians Listing with Tours of Duty and core hours.

§ Copies of all required documentation shown at 2c, above.

§ PT-MD's T&A Report" for January, February, and March 05

§ ELB Meeting Minutes for Calendar Year 2005 and CBIC for the same period.

§ Physical and Electronic Verification worksheets

The OIG CAP Team evaluated the Part Time Physician's Time and Attendance and provided the following written statement:

“Part-Time Physicians. Time and Attendance Was Satisfactorily Monitored. The medical center employed 78 part-time physicians. These physicians signed attendance records, and timekeepers documented their attendance. The medical center established a well defined structure that conveyed time and attendance policies and responsibilities for employees, timekeepers, supervisors and others regarding approval and reporting of time and attendance information. Fiscal Service employees audited timekeepers' records three times a year, provided timekeeper training annually, and initiated appropriate corrections as warranted”

All the aforementioned actions taken, together with the Service Chiefs', Compliance Officer's, and the Fiscal Officer's continuous effort in the monitoring and completion of all required time and attendance documentation resulted in positive outcome of the OIG CAP review.

OIG Contact and Staff Acknowledgments

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