DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

April 7, 2017

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-16-3638

Dear Ms. Lerner:

I am responding to your November 3, 2016, request to the Department of Veterans Affairs (VA) for a report responding to a whistleblower's multi-faceted allegation regarding the miscoding of patient visits in the Emergency Department at the Louis A. Johnson VA Medical Center, Clarksburg, West Virginia (the Medical Center). The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary as referenced in 5 United States Code § 1213(d)(5).

In the enclosed report, VA substantiated two aspects of the allegation, cannot substantiate another aspect of the allegation, and does not substantiate the two remaining aspects of the allegation. VA makes three recommendations to the Medical Center, one to the Veterans Health Administration, and one at the Department level.

Thank you for the opportunity to respond.

Sincerely,

Vivieca Wright Simpson
Chief of Staff

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
Washington, DC

Report to the
Office of Special Counsel
OSC File Number DI-16-3638

Department of Veterans Affairs (VA)
Louis A. Johnson VA Medical Center
Clarksburg, West Virginia

Report Date: March 23, 2017

TRIM 2016-D-2775

Executive Summary

The Under Secretary for Health requested that the Office of the Medical Inspector (OMI) assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the Louis A. Johnson VA Medical Center (the Medical Center) in Clarksburg, West Virginia. A person (the whistleblower), who chose to remain anonymous, alleged that employees are engaging in conduct that may constitute violations of law, rule or regulation, gross mismanagement, and an abuse of authority. The VA team conducted a site visit to the Medical Center on December 5–8, 2016.

Specific Allegation of the Whistleblower

For the last 7 years, Physician Assistant (PA) Employee 1 and Employee 2 have directed Emergency Department (ED) nursing staff to code ED patients in a manner that violates agency policy to improperly reduce reported wait times and number of patient visits.[1]

VA **substantiated allegations** when the facts and findings supported that the alleged events or actions took place and **did not substantiate allegations** when the facts and findings showed the allegations were unfounded. VA was **not able to substantiate allegations** when the available evidence was not sufficient to support conclusions with reasonable certainty about whether the alleged event or action took place.

After careful review of findings, VA makes the following conclusions and recommendations.

Conclusions for the Allegation

- VA **substantiates** the allegation that at times during the last 7 years, the Employee 1 attempted to influence ED nursing staff through directions she provided to the ED Nurse Manager to place certain patients into two unofficial sub-ED clinics and to use either primary care stop code (323) or medical stop code (329) in violation of Veterans Health Administration (VHA) policies. This in turn prevented accurate workload capture for ED providers and nurses. The decision to create sub-clinics within the ED and new profiles violated VHA Directive 1731; the failure to use primary stop code 130 for all ED encounters violated VHA Directive 1101.05. These actions could have improperly reduced reported ED wait times and the number of unique ED encounters. Use of unsanctioned primary stop codes to capture work delivered in the ED Emergency Severity Index 5 Clinic and the ED Procedure Clinic would have given the false impression that the PC Clinic had a greater workload (and demand for services) than it did in fact.

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[1] Employee 1 was incorrectly identified as Quality Assurance Specialist in the OSC referral letter, November 3, 2016. Employee 2 is the former Associate Chief Nurse, Primary Care.

- VA **did not substantiate** that for the last 7 years, the [redacted] directed ED nursing staff to code ED patients in a manner that violates agency policies for the purpose of reducing reported wait times and the number of unique patient visits.

- **VA substantiates** that the former Associate Chief of Staff (CoS) for Patient Care Services received a $3,400 Performance Award associated with the fiscal year (FY) 2012 Executive Career Field Performance Review. The CoS rated the Associate CoS [redacted] for the Service Specific Element, noting "Marked decrease in unique Veterans using ER care instead of Primary Care," as an accomplishment under the element which correlates with the inaccurate data displayed in Table 1.

- **VA was not able to substantiate** that the Employee 1 had performance goals related to, or had received performance awards specifically for, achieving a reduction in ED patient wait times and in the number of unique ED patient visits.

- **VA did not substantiate** that the [redacted] had received performance awards for performance objectives related to reduction in ED patient wait times and in the number of unique ED patient visits during the time period reviewed.

Recommendations to the Medical Center

1. As conveyed during the investigative team's exit briefing, the Medical Center must immediately stop using the primary stop codes 323 and 329 for patients treated in the ED by ED staff. The Medical Center should work with VHA's National Managerial Cost Accounting Office to set up an outpatient procedure clinic that complies with VHA Directives 1731 and 1101.05.

2. Comply with VHA Directive 1230, which requires VA facilities to use an electronic Clinic Profile Management process to change, request, and approve profiles for clinics. Create a Charter for the Clinic Creation Committee and incorporate this process into the Medical Center's policy. The Charter should identify committee members, their responsibilities, and attendance requirements. The committee should include representation from Health Administration Service, Decision Support System, and Health Information Management Service and a representative of the Medical Center Director. Step-by-step requirements for clinic creation requests with an approval timeline should be identified, and the Charter should mandate that a Managerial Cost Accounting site team reviews all stop code assignments for accuracy, based upon proposed services and workload.

3. Conduct a meeting with ED leadership and staff to review requirements of VHA Directive 1101.05.

Recommendation to VHA:

1. Arrange with VHA's Office of Finance, National Managerial Cost Accounting Office, to assign a DSS ID subject matter expert to conduct a site visit to this Medical Center to evaluate clinic creation processes and procedures, and to provide education to the Executive Leadership Team and other relevant Medical Center, ED, and PC leadership regarding the purpose and importance of appropriate clinical mapping and correctly creating clinics to ensure accurate workload capture and costing.

Recommendation to VA:

1. The VA Office of Accountability Review (OAR) should assess the actions of Medical Center Executive Leadership regarding the FY 2012 Executive Career Field evaluation of the former Associate CoS, PC and associated performance bonus. Proceed with appropriate actions, if warranted.

Summary Statement

OMI has developed this report in consultation with other VHA and VA offices to address OSC's concerns that the Medical Center may have violated law, rule or regulation; engaged in gross mismanagement, and abuse of authority. In particular, the Office of General Counsel has provided a legal review; VHA Human Resources has examined personnel issues to establish accountability; OAR has reviewed the report and has or will address potential senior leadership accountability; and the National Center for Ethics in Health Care has provided a health care ethics review. We found violations of VHA policy.

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I. Introduction

The Under Secretary for Health requested that the Office of the Medical Inspector (OMI) assemble and lead a Department of Veterans Affairs (VA) team to investigate an allegation lodged with the Office of Special Counsel (OSC) concerning the Louis A. Johnson VA Medical Center (the Medical Center) in Clarksburg, West Virginia. A person (the whistleblower), who chose to remain anonymous, alleged that employees are engaging in conduct that may constitute violations of law, rule or regulation, gross mismanagement, and an abuse of authority. The VA team conducted a site visit to the Medical Center on December 6–8, 2016.

II. Facility Profile

The Medical Center, part of Veterans Integrated Service Network (VISN) 5, is a tertiary care facility serving approximately 70,000 Veterans in North Central West Virginia and neighboring counties in Pennsylvania, Ohio, and Maryland, with inpatient services in acute medicine, surgery, acute psychiatry, Substance Abuse Residential Rehabilitation Treatment Program (SARRTP), posttraumatic stress disorder (PTSD), Residential Rehabilitation Program (PRRP), Psychosocial Residential Rehabilitation Treatment Program (PRRTP), and nursing home care. Its outpatient services include ambulatory surgery, audiology, cardiology, dental, dermatology, diabetes, Ear, Nose, & Throat, gastroenterology, general internal medicine, general surgery, gynecology, hematology/oncology, infectious disease, nephrology, nutrition, occupational therapy, ophthalmology, optometry, pain, physical therapy, podiatry, primary care, prosthetics, behavioral medicine (including substance abuse, telepsychiatry, PTSD, etc.) pulmonology, recreation therapy, rheumatology, social work, speech pathology, urology, and vascular surgery. The Medical Center maintains Joint Commission accreditation for Acute Hospital Care, Mental Health Specialty Care, Home Care, and Long-Term Care, and trains over 60 residents/fellows from various affiliation agreements in a typical fiscal year. The Medical Center has an eight-bed Emergency Department (ED) that is aligned under the Primary Care (PC) Service.

III. Specific Allegation of the Whistleblower

For the last 7 years, Physician Assistant (PA) Employee 1 and Employee 2 have directed Emergency Department (ED) nursing staff to code ED patients in a manner that violates agency policy to improperly reduce reported wait times and number of patient visits.[2]

IV. Conduct of Investigation

The VA team conducting the investigation consisted of M.D., FACP, FACHE, Medical Investigator; MS, BSN, RN, NE-NC, Clinical Program

Employee 1 was incorrectly identified as Quality Assurance Specialist in the OSC referral letter, November 3, 2016. Employee 2 is the former Associate Chief Nurse, Primary Care.

Manager, both of OMI; Decision Support System (DSS) Specialist, VISN 8; and Human Resources (HR) Labor Relations Specialist, Indianapolis VA Medical Center. Lead Clinical Analyst Managerial Cost Accounting Office Database Development, Veterans Health Administration's (VHA) Office of Finance, served as a subject matter expert for the investigative team. We reviewed relevant policies, procedures, professional standards, reports, memorandums, and other documents listed in Attachment A. We toured the Medical Center's ED, held entrance and exit briefings with Medical Center leadership, and interviewed the following employees:

- Associate Chief Nurse (ACN), Primary Care (PC)
- current ED Nurse Manager
- Employee 1 Physician Assistant (PA) and former Administrative Officer, Primary Care (AO, PC) (incorrectly identified as Quality Assurance Specialist in the November 3, 2016, OSC referral letter)
- Employee 2 RN, former ACN, PC
- ormer ED Nurse Manager
- RN, ED nurse
- RN, ED nurse
- RN, ED nurse
- RN, ED nurse
- RN, former ED nurse
- , RN, Special Projects, Nursing Service and former ED nurse
- Chief, Fiscal and former Acting HR Officer
- DSS Coordinator (part-time)
- DSS Coordinator (part-time)
- M.D., ED Physician
- M.D., ED Physician
- M.D., ED Medical Director
- Chief, Health Administration Service (HAS)/Business Office
- ED Medical Support Assistant (MSA)
- ED MSA
- RN, Associate Director, Patient Care Services (AD, PCS)
- M.D., Chief of Staff (CoS)
- RN, Chief, Quality Management
- PA-C, ED PA
- Systems Redesign Specialist
- Chair, Clinic Creation committee

V. Background

VA assigns a specific DSS Identifier (DSS ID), also known as a stop code, to outpatient clinical work units for costing purposes.[3] Stop codes capture workload for outpatient

[3] VHA Directive 1731, *Decision Support System (DSS) Outpatient Identifiers*, May 29, 2013.

clinics and are used to gather data in support of continuity of patient care, resource allocation, performance measurement, quality management, and third party collections. Directive 1731 states that it is essential for VA medical centers to correctly use the designated stop codes and not to deviate from nationally-directed standards. Stop code data define workload, which is critical to VA facilities for costing purposes. VHA also uses these data to compare costs between facilities. Stop codes are critical for costing to the product level.

Consistent with the requirements of the Directive, paragraph 4.a., the National Stop Code Council is responsible for maintaining, publishing and updating an accurate national list of all codes, for collaborating with clinical program offices to develop stop codes, to support codes/definitions for new program initiatives, and for serving as a resource for the field. In addition, paragraph 4.b. requires each VISN to have a DSS Coordinator responsible for reviewing and requesting new stop codes from each VISN station to ensure each is compliant. Moreover, paragraph 4.c., requires each Medical Center Director to be responsible for ensuring the facility is compliant with the current stop codes.

Per the Directive, paragraph 6. (c)-(d), there are two stop code classifications to be used by the field:

Primary stop code: A three digit DSS ID that designates the main clinical group responsible for the care. The primary stop code must always be the first three characters of a DSS ID for it to be valid.

Secondary stop code: A three digit DSS ID that comes after the primary stop code; used to further define the primary work group. For example, 323-710 is a PC Clinic with the assigned primary stop code 323 that has a secondary stop code 710 to identify it is the vaccine clinic. Not all primary stop codes have secondary stop codes.

The Directive also establishes that DSS site teams, in conjunction with their clinical programs, are responsible for annually reviewing and verifying that stop codes are correct and in compliance with the DSS IDs Instructional Guide, referenced in the directive and found on an internal VA Web site. The Instructional Guide outlines how to use and pair primary and secondary DSS IDs for workload collection, stating:

> Workload data must be captured through electronic means including electronic encounter forms. The stop codes selected for a clinic may 'appear invisible' to a provider but they were chosen for each clinic when the clinic profile was established. For example, the 'Red Stripes Clinic' would have stop codes associated with the clinic that identifies the workgroup providing the care. Stop code assignments to clinics provide data that medical centers are required to report to the National Patient Care Database (NPCD). The NPCD only recognizes the primary stop code in workload reports.[4]

[4] VHA Handbook 1731, *Decision Support System (DSS) Outpatient Identifiers*, May 29, 2013.

Managerial Cost Accounting labor mapping is the assignment of labor costs to functional work areas. To ensure that VA cost information is accurate and useful, employees must have their hours and salary correctly mapped into the functional cost centers where they perform their duties. ED providers and nurses should be mapped to the cost center created for the ED. A clinical staff member is mapped to multiple cost centers if he or she works in multiple workload environments.[5] For example, a provider working 10 hours/week in the PC Clinic and 30 hours/week in the ED would be mapped 25 percent to the PC Clinic and 75 percent to the ED. It is important that labor mapping for providers coincides with their workload in order to prevent skewing the cost of patient care and to ensure data integrity for national cost reporting and comparisons.

Since 2007, VA has required facilities to use the DSS ID or stop code 130 "Emergency Department" for ED workload.[6] Paragraph 10 of VHA Directive 1101.05, *Emergency Medicine* (dated September 2, 2016, and amended October 27, 2016) directs the field to use stop code 130 for all patients treated in the ED (including patients treated in the ED's fast track) regardless of the reason for the ED visit, the severity of their illness, or Emergency Severity Index (ESI) triage level. The ESI triage algorithm yields rapid, reproducible, and clinically-relevant stratification of patients into five groups and provides a methodology for categorizing ED patients by acuity and resources needed. The ESI Levels range from one to five: level one indicates the patient requires immediate life-saving intervention and level five indicates the patient is stable, with minimal resources needed for their care.[7] Further, Directive 1101.05 requires in paragraph 9.b. that RN triage in all EDs use the ESI as the sole triage tool.

VI. Findings, Conclusions, and Recommendations

Findings

Prior to completion of its extensive renovation in 2010, the facility's ED had 5 beds in one section and a fast-track side where designated ED providers and nurses could treat patients with lower severity of illnesses, whose ESIs ranged from 3 to 5. Since 2010, the ED consists of a single designated area of eight beds where all patients are triaged and treated.

VA implemented a Fiscal Glide Path Tool in FY 2011 to assist VHA facilities in identifying opportunities for efficiencies that could help with financial scenario planning for FYs 2012 and 2013.[8] In FY 2011, the Medical Center identified incomplete and duplicated ED encounters as an opportunity for improvement. Incomplete encounters occurred when the ED clerk or nurse did not check out patients after they had been triaged. This largely occurred in instances when patients were triaged, determined to

[5] VHA Directive 2011-009: Physician and Dentist Labor Mapping, February 28, 2011.
[6] Email sent to VHA Emergency Medicine Leaders mail-group, from [redacted] National Director for Emergency Medicine, April 18, 2007.
[7] Gilboy, N., Tanabe, P., Travers, D., Rosenau, A., (2012). *Emergency Severity Index (ESI): A Triage Tool for Emergency Department Care.* AHRQ Publication No. 12-0014.
[8] The VA Fiscal Glide Path Tool is designed to separate random financial events from true inefficiencies while identifying and setting efficiency targets.

be non-urgent (ESI levels of 4 or 5), were subsequently referred to the PC Clinic for treatment. In these cases, each patient should have two coded encounters: one for the ED nurse triage and one for the treatment by the PC provider. The Medical Center submitted an action plan to its VISN on December 1, 2011, reporting multiple opportunities for improvement with regard to ED utilization. Included in its report was an analysis identifying excessive utilization of the ED stop code, evidenced by the high rate of ED encounters.[9]

The ESI 5 Clinic

On June 6, 2011, the Medical Center initiated a new clinic within the ED called the ESI 5 clinic. According to several interviewees, the intention was to use the ESI 5 clinic for any ED patient assigned an ESI level of 4 or 5 after assessment by the ED triage nurse. This clinic had neither a designated space within the ED nor designated ED staff whose work could have been labor mapped to the PC Clinic.

This clinic was assigned a primary stop code of 323, a PC Clinic code. Use of this stop code wrongly directed workload credit for care provided by ED staff to the PC Clinic: only ED providers and nurses provided care to patients in the ESI 5 clinic. The use of this stop code violated VHA Directive 1101.05 that requires all ED encounters to use stop code 130.[10] The Medical Center deactivated the ESI 5 clinic on August 24, 2015, shortly after a June 2015 Office of Inspector General (OIG) inquiry regarding allegations of false documentation in the medical records of patients who came to the ED for care who were determined to be "non-emergent" and who did not have a life-threatening medical need. Although the former AO, PC informed OIG that these patients are sent to the clerk to schedule an appointment with their PC provider, we found that patients were also scheduled to be seen in the ESI 5 clinic until it was deactivated.[11]

The ED Procedure Clinic

On March 6, 2012, the Medical Center initiated a Procedure Clinic within the ED. According to several interviewees, the ED Procedure Clinic stop code was intended for patients who came to the ED for procedures such as paracentesis, suture removal, bandage changes, joint injections, intravenous (IV) access management, IV antibiotics, and some diagnostic procedures that require interval evaluations, injections, or specimen collection. Services provided by the Procedure Clinic were captured by the primary stop code of 329, with a secondary stop code of 117 that is nonspecific and indicates only that an RN or an LPN conducted an assessment, provided education, and furnished treatment services.[12]

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[9] *Medical Center Action Plan*, December 1, 2011.
[10] VHA Directive 1101.05, *Emergency Medicine Handbook*, September 2, 2016, amended October 27, 2016. Note this was the same stop code requirement set forth in prior policy, including VHA Handbook 1101.05 dated May 10, 2010.
[11] OIG Referral 2015-04085-HL-1443.
[12] http://vaww.dss.med.va.gov/programdocs/pd_oident.asp.

In FY 2013, the secondary stop code was removed from the system; the Employee 1 could not explain why it had been removed. We found that while only ED providers and nurses provided care to patients assigned to the Procedure Clinic, they received no workload credit because stop code 329 was used instead of stop code 130. ED visit costs appeared to inflate because the ratio of ED costs to workload per ED case was not being accurately reflected. For example, if an ED provider worked 30 hours on ED patients assigned to the 130 stop code and 10 hours on Procedure Unit patients assigned the 329 stop code, the 10 hours of labor for the latter are captured in the ED because the provider is mapped to that stop code 100 percent of the time.

Per VHA policy, providers and nurses must be labor mapped to the clinic stop code where they provide care. Primary Stop Code 130 must therefore be used to capture care furnished to patients by ED providers in the ED Procedure Clinic, which again is located in the same ED space used by other ED patients. The facility's administrative practice of not using stop code 130 for all patients triaged and treated in the ED Procedure Clinic violated the requirements of the *Emergency Medicine* Directive referenced above.[13]

In summary, rather than assigning individual stop codes to both administratively-created sub-clinics created within the ED, the facility should have followed national policy and used only primary stop code 130 for those encounters.

Additional Findings

The Medical Center created a Clinic Creation Committee (CCC) tasked with reviewing new clinic profile requests, including clarification of the types of clinical services provided and the type of clinicians assigned. We found; however, that attendance at CCC meetings was poor. At the time of our site visit, the CCC had not met for several months. We also found that new clinic profile requests are frequently made via email and subsequently approved and created outside of this Committee. In addition, when it does meet, the CCC does not keep reliable minutes; the meeting notes that were available were found to be limited and difficult to interpret. The Medical Center was unable to produce any records or notes whatsoever pertaining to the requests to create the ESI 5 and ED Procedure Clinics.

As a result, we found the manner in which each of the two sub-clinics within the ED were established and operated was not compliant with VHA Directive 1230, *Outpatient Scheduling Processes and Procedures,* which requires facilities to use an electronic Clinic Profile Management process to change, request, and approve clinic profiles.[14] This facility practice may also call into question the accuracy of all the clinic profiles created at the Medical Center for other service lines.

We reviewed email communications from the Employee 1 o the ED Nurse Manager for November–December 2013 (Attachment B), in which the Employee 1 indicated there were

[13] VHA Directive 1101.05, *Emergency Medicine Handbook*, paragraph 10.
[14] VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016.

problems with the number of patients being placed in the ED clinic and that this was affecting performance measures. She identified two patients from the previous day and asked the ED Nurse Manager to change the patients to the ED Procedure Clinic and to cancel the ED visits. The ED Nurse Manager responded by requesting a Standard Operating Procedure (SOP) to clarify which patients were to be placed in the ED Procedure Clinic in the future. The Employe 1 esponded by sending a list to the ED Nurse Manager, who then forwarded the information to all ED nurses. The Medical Center could not produce an SOP regarding patient placement in the ED Procedure Clinic.

We also reviewed email communications between the Employee 1 the Employee 2 the ED Medical Director, the Associate CoS, the ED Nurse Manager, the AD, PCS, and the ED Nurse Manager. In this exchange, the Employee 1 ndicated the Medical Center had "the largest number of ED visits and the goal is to decrease this number...." The ED Nurse Manager requested a meeting to discuss her concerns. Clinical leadership included in these email communications indicated that they would meet to address her concerns; however, we could find no evidence that any such meeting ever took place. The Medical Center was unable to provide meeting minutes or other documentation. The ED Nurse Manager likewise requested an SOP from the Employee 1 identifying the clinical services to be provided in the ESI 5; however, we could find any evidence of an SOP, written policy, or related training developed for ED nursing staff.

We interviewed a total of six nurses currently employed at the facility. Four currently work in the ED, and the remaining two have transferred to another unit within the facility in the last 18 months. All six reported concerns about the use of the additional clinic stop codes (323 and 329) for ED patients triaged as ESI 4 or 5, and for patients who required a procedure. All reported that they believed the use of these stop codes manipulated data, making it look like some ED patients had received care outside of the ED when that was not the case. All reported that they use their nursing education combined with clinical judgment to assign an ESI level when triaging ED patients. They document the ESI level for each patient in the electronic health record (EHR), and the MSA then registers the patient into the ED, using a stop code of 130. We found these actions appropriate and to be within the standard of care.

The same nurses also reported that they had each received phone calls from the Employee 1 Employee 1 questioning their clinical judgment in assigning ESI levels of 3 or 4 to certain patients. They also reported that the Employee 1 and Employee 2 had directed ED nursing staff members to tell the MSAs to schedule ED patients with an ESI level of 5 into the ESI 5 clinic and patients requiring procedures into the ED Procedure Clinic. When we asked these ED nurses whether the Employee 1 or Employee 2 had given them these instructions directly, all nurses said "no" and explained that they had only received forwarded emails on the subject from the ED Nurse Manager.

Manipulation of ED Data

The Employee 1 reported that sometime prior to 2010, someone had told her the Medical Center had the highest number of ED visits of all the VA medical centers in the

country and directed her to look into it. When asked to identify this individual, she could not recall who it was. She reported that she looked at ED encounters daily to monitor utilization. She said that 60 percent of the patients were ESI 4s and 5s and further that "we" had to explain how much ED visits cost when the care was not at the ED level. When asked, she could not identify to whom the "we" referred.

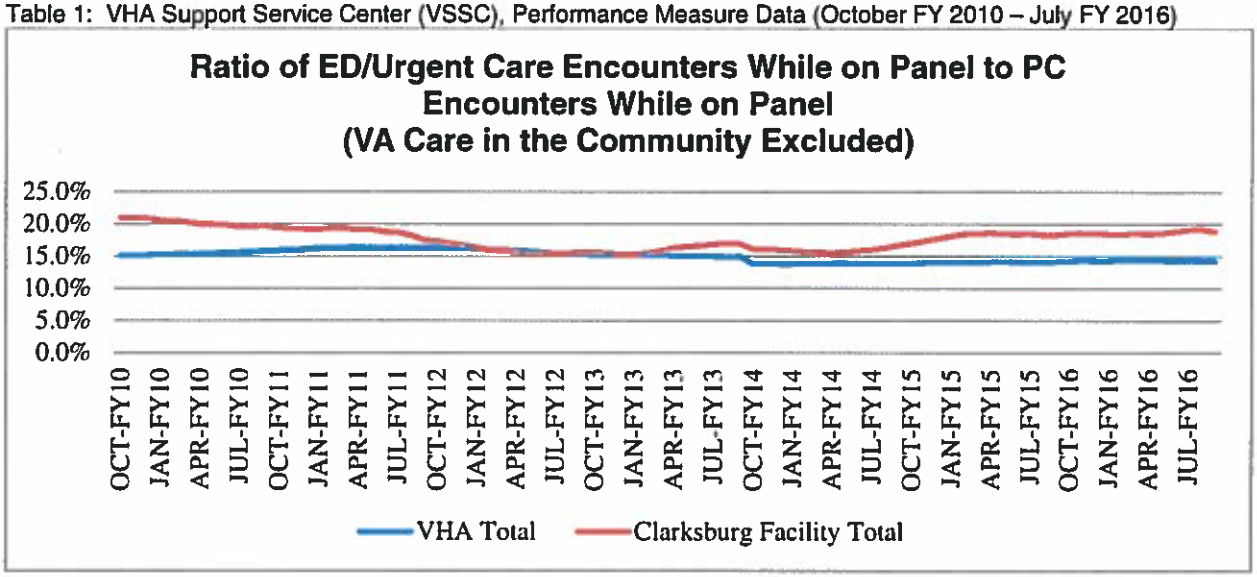
The Employee 1 reported she initiated the ESI 5 clinic with a primary stop code of 323 partly to help Veterans who are obligated to pay VA copayments: the copayment amount for specialty care is significantly greater than that assessed for primary care. Because they could have been treated in the PC Clinic, she believed stop code 323 more properly applied to them even though they had presented to the ED where they were triaged by ED staff. While it is true that there is a difference in copayment amounts, VHA Directive 1731 requires clinic coding to be based solely on proper workload identification, not other factors.

Although she was responsible for ED operations through 2013, the Employee 2 was not aware of the requirement in VHA Directive 1101.05 to use stop code 130 for all ED visits, that the ESI 5 and ED Procedure Clinics had their own stop codes assigned to them, and that the use of unsanctioned stop codes other than stop code 130 violated past and current VHA Emergency Medicine policy. She stated that "it didn't matter where they were as long as they were treated." She did not recall whether ED nurses were mapped to the ESI 5 and ED Procedure Clinics for workload credit; and she referred us to the Special Projects Nurse, who thought the ED nurses were not mapped for workload credit.

It is indisputable; however, that VHA Handbook 1101.05 and the successor current directive both specify that all patients seen in the ED must be assigned the ED stop code 130. The Employee 1 was responsible for requesting the creation of new clinics in the manner required by VHA Directive 1731 and for mapping labor hours of the ED Providers properly to ensure their workload was accurately captured. Notably, she did not have any authority over, or responsibility for, changing the labor mapping for work performed by the ED nurses.

We interviewed the CoS (former Associate CoS) who was also unaware that the ESI 5 and ED Procedure Clinics were created using non-ED stop codes, or that use of anything other than stop code 130 for ED visits violated current VHA Directive 1105.05 or the previous Handbook. She reported that it was her belief that these two clinics were created within the ED to improve patient flow.

Table 1: VHA Support Service Center (VSSC), Performance Measure Data (October FY 2010 – July FY 2016)



VHA monitored the number of ED/Urgent Care encounters for patients assigned to a Primary Care Panel as a performance measure in FY 2010-2016. Table 1 reflects a 5 percent downward trend for the Medical Center that matched the national average in FY 2012-2013. This is significant because none of the staff members we interviewed could recall a performance measure that monitored ED encounters for patients assigned to a PC panel, yet we discovered that the former Associate COS received a performance award during this period for this very measure. The establishment of the ESI 5 clinic in June 2011, and the ED Procedure Clinic in March 2012, with the use of stop codes 323 and 329, respectively coincide with a downward trend that started in July 2011. The use of the ESI 5 and ED Procedure Clinic stop codes generated inaccurate data by decreasing the number of reported ED encounters of patients assigned to a PC panel. However, due to the nursing staff's vigilance in raising concerns about data manipulation, the impact of these improper practices was minimal. As of January 2015, utilization data indicated that patients seen in the ED stop code 130 accounted for 92 percent of all ED patients, with the remaining 8 percent being seen in the ESI 5 Clinic (323), ED Procedure Clinics (329), or the Phone Triage Clinic.

We reviewed FY 2010–2016 Performance Plans for the former Associate COS for PC, (the current CoS), the Employee 1, the Employee 2 and the AD, PCS, and found no evidence that the Employee 2 or AD, PCS were evaluated upon their ability to reduce either ED wait times or the number of unique patient encounters. There is evidence that the Employee 1 was evaluated on PC Performance Measures in general; but no specific ones were identified in her performance plan. Therefore, we could not definitively determine whether the Employee 1 had performance goals related to, or had received performance awards specifically for, meeting performance measures associated with the subject allegation. We did find evidence that the former Associate CoS had received a $3,400 Performance Award associated with the FY 2012 Executive Career Field (ECF) Performance Review in which the CoS had rated him for the Service Specific Element, while

noting under that element "Marked decrease in unique Veterans using ER care instead of Primary Care."

Conclusions

- We **substantiate** the allegation that at times during the last 7 years, the Employee 1 attempted to influence ED nursing staff through directions she provided to the ED Nurse Manager to place certain patients into two unofficial sub-ED clinics and to use either primary care stop code (323) or medical stop code (329) in violation of VHA policies. This in turn prevented accurate workload capture for ED providers and nurses. The decision to create sub-clinics within the ED and new profiles violated VHA Directive 1731; the failure to use primary stop code 130 for all ED encounters violated VHA Directive 1101.05. These actions could have improperly reduced reported ED wait times and the number of unique ED encounters. Use of unsanctioned primary stop codes to capture work delivered in the ED ESI 5 Clinic and the ED Procedure Clinic would have given the false impression that the PC Clinic had a greater workload (and demand for services) than it did in fact.

- We **did not substantiate** that for the last 7 years, the Employee 2 directed ED nursing staff to code ED patients in a manner that violates agency policies for the purpose of reducing reported wait times and the number of unique patient visits.

- We **substantiate** that the former Associate CoS for PCS received a $3,400 Performance Award associated with the FY 2012 ECF Performance Review. The CoS rated the Associate CoS r the Service Specific Element, noting "Marked decrease in unique Veterans using ER care instead of Primary Care," as an accomplishment under the element, which correlates with the inaccurate data displayed in Table 1.

- We **could not substantiate** that the Employee 1 had performance goals related to, or had received performance awards specifically for, achieving a reduction in ED patient wait times and in the number of unique ED patient visits.

- We **did not substantiate** that the or had received performance awards for performance objectives related to reduction in ED patient wait times and in the number of unique ED patient visits during the time period reviewed.

Recommendations to the Medical Center

1. As conveyed during the investigative team's exit briefing, the Medical Center must immediately stop using the primary stop codes 323 and 329 for patients treated in the ED by ED staff. The Medical Center should work with VHA's National Managerial Cost Accounting Office to set up an outpatient procedure clinic that complies with VHA Directives 1731 and 1101.05.

2. Comply with VHA Directive 1230, which requires VA facilities to use an electronic Clinic Profile Management process to change, request and approve profiles for clinics. Create a Charter for the CCC and incorporate this process into the Medical Center's policy. The Charter should identify committee members, their responsibilities and attendance requirements. The committee should include representation from Health Administration Service, Decision Support System, and Health Information Management Service, and a representative of the Medical Center Director. Step-by-step requirements for clinic creation requests with an approval timeline should be identified, and the Charter should mandate that a Managerial Cost Accounting site team reviews all stop code assignments for accuracy, based upon proposed services and workload.

3. Conduct a meeting with ED leadership and staff to review requirements of VHA Directive 1101.05.

Recommendation to VHA:

1. Arrange with the VHA Office of Finance, National Managerial Cost Accounting Office, to assign a DSS ID subject matter expert to conduct a site visit to this Medical Center, to evaluate clinic creation processes, and procedures, and to provide education to the Executive Leadership Team and other relevant Medical Center, ED, and PC leadership, regarding the purpose and importance of appropriate clinical mapping and correctly creating clinics to ensure accurate workload capture and costing.

Recommendation to VA:

1. The VA Office of Accountability Review (OAR) should assess the actions of Medical Center Executive Leadership regarding the FY 2012 Executive Career Field evaluation of the former Associate CoS, PC and associated performance bonus. Proceed with appropriate actions, if warranted.

VII. Summary Statement

OMI has developed this report in consultation with other VHA and VA offices to address OSC's concerns that the Medical Center may have violated law, rule or regulation; engaged in gross mismanagement and abuse of authority. In particular, the Office of General Counsel has provided a legal review; VHA HR has examined personnel issues to establish accountability; OAR has reviewed the report and has or will address potential senior leadership accountability; and the National Center for Ethics in Health Care has provided a health care ethics review. VA found violations of VHA policy.

Attachment A

Documents in addition to the Electronic Medical Records reviewed:

VHA Handbook 1101.05, *Emergency Medicine Handbook*, May 12, 2010.

VHA Directive 1101.05, *Emergency Medicine*, September 2, 2016, and amended October 27, 2016.

VHA Handbook 1101.10, *Patient Aligned Care Teams (PACT) Handbook*, February 5, 2014.

VHA Directive 1731, *Decision Support System (DSS) Outpatient Identifiers*, May 29, 2013.

VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016.

Medical Center Standard Operating Procedure 118-89, *Triage of the Patients for Emergency Department Care*, March 2014.

Medical Center Action Plan, December 1, 2011.

OIG Hotline Referral Case 2015-04085-HL

Performance Plans

Email Correspondence

Attachment B

On November 18, 2013, the Employee 1 sent an email to the ED Nurse Manager that said "this has got to stop!!! We are having too many [patients] being placed in the [ED] clinic inappropriately which is causing a lot of problems with action[s] [required] and performance measures such as the [ED] utilization and [ED] duplicate encounters." The email continued with a request to "please change the following [patients] to the [ED Procedure clinic] and cancel the [ED] visits from yesterday."

On November 22, 2013, the ED Nurse Manager emailed the Employee 1 and courtesy copied the current CoS (who was serving as the Associate CoS at that time) and the Employee 2 who was serving in that role at that time to ask, "is there anything in writing (like a standard operating procedure or memorandum) defining [the] types of patients that you want to go in the ED Procedure clinic? I want to educate my staff and it would be easier if I had some kind of document to refer to." The Employee 1 replied to all on November 25, 2013. "There isn't [a standard operating procedure] since it is hard to define the different procedures that go into it. I guess we can come up with a list and hope that we don't forget something." The list of procedures is listed in the body of the report and includes paracentesis, suture removal, bandage changes, joint injections, intravenous access management and antibiotics, and some diagnostic procedures that require interval evaluations, injections and/or specimen collection.

On December 3, 2013, the ED Nurse Manager forwarded the above email to all ED nurses with the message "FYI."

On April 25, 2014, the Employee 1 emailed the ED Nurse Manager and Associate CoS to say, "I review the emergency department visits every day and I have noticed that there are days that no [patients are placed in the [ESI 5 clinic] instead of the [ED]. Are there new nurses that are not familiar with this or has someone told your nurses to stop placing pts in the [ESI 5 clinic]. I review the [patients] and there are several [ESI] 5 and 4 [patients] that could easily be placed into the [ESI 5 clinic] instead of [ED] clinics. Also I am noticing that we are not using the [ED Procedure Clinic] either. [Two] days ago there were [two patients,] one for suture removal and one for rabies vaccine that were placed in [the ED] clinic and should have been placed in the [ED Procedure clinic]. Please remind [your] staff to use both [clinics] since our [ED] utilization is going to increase and then we will have to explain it. [Also] if your nurses are having problems with HAS not placing the patients into those clinics after the nurses informed them, we need to know. Also if you are hearing from providers not to use the [ESI 5 or Procedure clinic] we also need to know. Thanks."

On April 28, 2014, the Employee 1 mailed the ED Nurse Manager; Associate CoS; ED Medical Director Employee 2 and Associate Director, Patient Care Services: "This morning again it happened. [Patient in for a [diagnostic] test placed in the ED clinic--- should have been placed in the [ED Procedure Clinic.] (I was able to get that one changed). Also [two patients] that were seen this weekend. [One with [possible] conjunctivitis, told to return Monday morning so that ophthalmology could see him. The

second [patient] was a [patient] that was seen last night [who came in to the ED to get results]. Both of these [patients] were an [ESI] 5 and [ESI] 4 and were placed in the [ED] clinic?? Why? I called the [ED] looking for [the ED Nurse Manager], and was informed that she was off for a couple days and spoke to the charge nurse. Who argued with me about all [three] of these [patients] and that it takes nursing time that they need to get credit for??? She also informed me that she has worked here over 1 year and no one has ever explained the [ESI 5 or the ED Procedure Clinics] to her and does not know what [patients] are to be going into those clinics. She further informed me that I needed to come up with a list of [patients] that are to be in each clinic if I wanted them to use these clinics! She tried to explain to me that these [patients] take [ED] nursing resources and that the [patients] need to be placed where they get credit and I tried to explain that nursing does get credit for the [patients] no matter what clinic they are in. It is obvious that the nursing staff in the [ED] are either not familiar with the [ESI 5 clinic /ED Procedure Clinic] or are familiar with it and don't agree with it. Something must change here, I see our ED visit numbers increasing and that needs to stop! At one time we had the most [ED visits] in the country and had to explain it and came a long way in correcting this problem. Now, our [ED] visits are increasing and will need to explain this again, so please inform the nurses and make sure they are utilizing the correct clinics. Thanks"

In response, the Employee 2 replied to all the same day: "Please [follow-up] with the ED Nurse Manager. All staff [members were] informed of the difference with [ESI and ED Procedure Clinics]. I apologize for them not following procedure and will have the ED Nurse Manager discuss this again with each employee. There is no excuse for them not following the guidelines."

On May 28, 2014, the Employee 1 emailed the ED Nurse Manager; Associate CoS; ED Medical Director; Employee 2 and Associate Director, Patient Care Services stating "Still noticing that the [ESI] clinic is being used very little if any. I still have not gotten a response to this email." On May 29, 2014, the Associate Director, Patient Care Services responded asking if a workgroup could be pulled together. The Associate CoS responded "the Employee 1 had reminded everyone on multiple occasions. This is a chronic problem, please fix it ASAP." The ED Nurse Manager responded that the Employee 2 Employee 1 ; ED Medical Director; and she would like to set up a meeting with the Employee 1 to discuss [the issue] and that she will send out a meeting invitation. The Associate CoS and Employee 2 both responded with an indication that they would participate in a meeting. VA was unable to find any evidence that a meeting took place; the Medical Center was unable to provide meeting minutes or other documentation in relation to this email chain.