Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Hostile Work Environment and Quality of Care Issues Evansville Outpatient Clinic Evansville, Indiana

Report No. 05-03501-186

August 11, 2006

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244

Executive Summary

The purpose of the review was to determine the validity of allegations made by a complainant. The Evansville Outpatient Clinic (EOPC) is operated by the Marion, IL VA Medical Center. The complainant alleged that: (a) medical center management had created a hostile work environment and refused to meet with the EOPC staff, (b) staffing levels were insufficient and physician panel sizes were too large to provide safe care to patients, and (c) managers had restricted requests for radiology orders, laboratory tests, and procedures in order to save money, resulting in compromised patient care.

We did not substantiate the allegation of a hostile work environment at the EOPC or that medical center managers refused to meet with the staff. Medical center managers had reorganized the EOPC and some staff were angry with the changes. The EOPC had a representative on the medical center reorganization committee, allowing them the opportunity to voice concerns and suggest changes to management. We concluded it is within management's right to organize and supervise the EOPC staff. We did not substantiate that staffing levels were insufficient or panel sizes were too large to provide safe care. According to a Veterans Health Administration (VHA) directive, panel sizes may vary based on support staff for providers, number of patients treated, examination rooms available, and waiting times for appointments. Medical center management considered appropriate factors to determine panel sizes and have a plan to adjust staffing according to workload data. Most performance measures, including waiting times for next available appointments, patient satisfaction scores, and access measures, are at the fully successful or high levels. We did not substantiate that the medical center Chief of Staff (COS) inappropriately restricted radiology orders, laboratory tests, or procedures. However, no one at the medical center tracked and trended the number of cases the COS reviewed for clinical appropriateness or the number of requests approved or denied. There was no mechanism for a secondary review of denials. We concluded that medical center leadership is authorized to make changes to ensure patient safety, quality of care, and compliance with VHA guidelines and procedures. New EOPC managers are in place and need time to recruit and fill vacant positions, provide effective leadership, and improve communication internally and with the medical center.

We recommended that VHA management take actions to: (i) evaluate the current utilization review process and establish an appeal process when clinicians disagree with decisions and (ii) establish a performance improvement monitor to trend the clinical appropriateness of providers' orders for radiographic tests that require upper-level approval. VHA management agreed with the recommendations and provided acceptable improvement plans.

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

TO: Director, Veterans Integrated Service Network 15 (10N15)

SUBJECT: Alleged Hostile Work Environment and Quality of Care Issues, Evansville Outpatient Clinic, Evansville, Indiana

1. Purpose

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspection (OHI) conducted an inspection to determine the validity of allegations regarding a hostile work environment and quality of care issues at the Evansville Outpatient Clinic.

2. Background

The Evansville Outpatient Clinic (EOPC) is a community based outpatient clinic located in Evansville, Indiana, which is operated by the Marion, Illinois VA Medical Center (medical center). The EOPC provides primary and specialized care to 14,000 unique veterans annually and is staffed by 101 full-time equivalent employees. There are 10 primary care clinics, and services provided include mental health, rehabilitation, laboratory, radiology, pharmacy, eye care, and other specialty clinics.

We received a hotline complaint with the following allegations:

- Management has created a hostile work environment and refused to meet with the EOPC staff.
- Staffing levels were insufficient and physician panel sizes were too large to provide safe care to patients.
- Management had restricted requests for radiology orders, laboratory tests, and procedures in order to save money, resulting in compromised patient care.

In December 2004, the medical center initiated a system-wide reorganization of staff and processes based on the Baldridge Award[1] criteria and other performance improvement tools. Interdisciplinary teams from the medical center and its outpatient clinics were included. As part of the reorganization and based on the need to strengthen supervisory oversight at the EOPC due to clinic scheduling and leave administration practices, the medical center management initiated operational changes. Medical center management added an EOPC Administrative Officer position and expanded the position description of the EOPC Medical Officer (MO). The EOPC Manager was reassigned and an EOPC Clinical Nurse Officer position was added. The EOPC administrators who previously supervised the clinic applied for the EOPC MO and Clinical Nurse Officer positions, but medical center management did not select them because other candidates were more qualified.

Some EOPC staff told us they had communicated their concerns to congressional representatives, service organizations, and local newspapers. Medical center and Veterans Integrated Service Network (VISN) 15 managers met with the EOPC staff on several occasions.

At the time of our visit, the new MO had been on duty for less than 1 week and the Clinical Nurse Officer position was in the selection process. The Administrative Officer had been on duty since January 2005.

3. Scope and Methodology

The complainant filed the complaint with the OIG Hotline Division during the medical center OIG Combined Assessment Program review. While onsite from October 31–November 4, 2005, we interviewed managers, clinicians, and administrative staff at the medical center. We visited the EOPC on November 15–18 and interviewed staff members and administrators. We interviewed the complainant to obtain a better understanding of the allegations. We reviewed selected patients' medical records, staffing plans, policies, procedures, VHA directives, performance improvement documents,]congressional correspondence, and local newspaper articles. We specifically reviewed appointment management records to assess workload and to determine next available appointment times.

During our interviews, an EOPC staff member raised concerns regarding the Chief of Staff's (COS) denial of community fee basis requests. The staff provided one case for review. On November 1, 2005, an EOPC physician submitted a fee basis request for a needle biopsy of a lung mass in a terminally ill patient. The COS reviewed the patient's history and x-rays and concluded that the request for biopsy was urgent but not emergent. On November 2, 2005, he directed EOPC staff to contact the medical center Pulmonology Clinic for an appointment. When the appointment could not be scheduled

[1] The Malcom Baldridge National Quality Award is America's premier annual award for business excellence.

for 2 weeks, the COS approved the fee basis request. The allegation was not substantiated because the short time frame between the date of request (November 1, 2005) and the date of the fee basis procedure (November 9, 2005) did not affect the patient's prognosis or outcome. The patient expired on December 5, 2005.

Specific personnel actions will not be discussed within this report as they are beyond the scope of this investigation.

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

4. Inspection Results

Issue 1: Alleged Hostile Work Environment

We did not substantiate the allegation of hostile work environment at the EOPC or that medical center managers refused to meet with the staff.

Many of the EOPC staff members expressed anger regarding the EOPC organizational restructure. Some reported that they did not trust the reorganization committees. However, the EOPC had a subcommittee and a representative on the medical center committee. This representation allowed them the opportunity to voice concerns and suggest changes to management. The VISN 15 Chief Medical Officer (CMO) met with the EOPC staff to discuss concerns and felt that although both sides are well meaning, they have communication difficulties.

The EOPC clinicians showed us e-mails from the medical center COS, which they described as threatening. The e-mails we reviewed dealt with denials for requested diagnostic tests. Some physicians expressed that they did not want or need supervision or oversight from the COS. The COS's job description mandates that he ensure high clinical outcomes, balanced with cost-effectiveness. It is within his function to supervise and correct clinical practice that is not within the standard of practice. While the COS's e-mails were strongly worded, they did not contain unprofessional language or threats.

Although some clinic staff are angry with changes in management, administrative practices, and workload expectations at the EOPC, others feel that it is part of the change process. We concluded it is within management's right to organize and supervise the EOPC staff. The new EOPC managers need the opportunity to address issues and implement corrective actions.

Issue 2: Staffing Levels and Panel Sizes

We did not substantiate that staffing levels were insufficient or panel sizes were too large to provide safe care.

There were two primary care physician vacancies at the time of our review. One had been vacant since August 2005 and the other since September 2005. Management provided evidence of active recruitment when the vacancies occurred. Medical center management hired one *locum tenens*[2] to fill in during the search for permanent physician staff. The MO position was vacant for 1 month and was filled in November 2005.

The EOPC operates 10 primary care clinics. Each clinic has a team that consists of a physician, a registered nurse, a licensed practical nurse, and a patient services assistant. According to VISN 15 and medical center managers, the staffing combination supports a larger patient panel size.

VHA Directive 2004-031 provides guidance on determination of panel size. Panel sizes vary from site to site based on multiple variables such as support staff for each provider, number of patients treated, examination rooms available, and waiting times for the next available appointment. The Directive also states, "a given site may have panel sizes that exceed expectations derived from this guidance. Provided excellent performance in the areas of quality, access, patient service and staff satisfaction is demonstrated, such variation may represent best practices and is fully acceptable under this Directive." Medical center management considered the factors, along with the lack of concurrent duties for the providers, to determine panel size. The providers do not have on-call obligations, medical resident teaching duties, or inpatient responsibilities. Operational hours are from 8:00 a.m.–4:30 p.m. Monday–Friday.

In August 2005, a new outpatient clinic opened approximately 40 miles from the EOPC. Medical center managers anticipate that 900 EOPC patients will transfer their care to the new clinic.

We compared panel sizes and next available appointments for the EOPC providers. Panel sizes ranged from 957–1,712 patients. Panel sizes vary because some physicians have collateral duties such as management of specialty clinics. The former MO had a panel size of 419 patients in addition to administrative responsibilities. On average, providers saw 14–17 patients per day. For 9 of 10 primary care teams, the waiting time for a next available appointment was 1 day. For the remaining team (a panel size of 1,156), the next available appointment was 3 days.

Since 2001, four primary care clinics have been added to the EOPC. Additional clinical staff have been added in psychology and social work. Medical center managers stated that they will continue to recruit for provider vacancies and that they are prepared to respond with additional staff should workload changes increase beyond expectation.

[2] *Locum tenens* - A Latin term literally meaning "place holder"; it means a person who substitutes temporarily for another member of the same profession.

We concluded that medical center managers considered appropriate factors to determine panel sizes and have a plan to adjust staffing according to workload data. Another outpatient clinic has opened which should shift patients from the EOPC and reduce panel sizes. It is acknowledged that some EOPC staff are not satisfied with current staffing and panel sizes. However, most performance measures, patient satisfaction scores, and access measures are at the fully successful or higher levels. Waiting times for next available appointments do not support the allegation of insufficient staffing. Furthermore, new management is in place at the EOPC and needs time to fully evaluate and implement changes based on data.

Issue 3: Restriction of Diagnostic Tests and Procedures

We did not substantiate that the medical center COS inappropriately restricted radiology orders, laboratory tests, or procedures.

VISN 15 requires that medical centers perform utilization reviews on high cost procedures in order to effectively manage resources. The medical center has a utilization review process in place for high cost radiology and other diagnostic tests and procedures. National or VISN-developed clinical practice guidelines are used to determine indications for specific tests or procedures. Medical center physicians have been included in the development of these guidelines and have the opportunity to provide input to proposed guidelines or changes to existing guidelines. The medical center COS has discussed the guidelines at medical staff meetings that include the EOPC medical staff.

The medical center COS reviews all requests for magnetic resonance imaging, computed tomography, and positron emission tomography scans to determine clinical appropriateness. He utilizes clinical guidelines and evidence-based practice to evaluate requests. Some EOPC providers stated that their clinical decisions should not be questioned, as they only order what they think is appropriate for patients.

The COS told us that he relies on providers to document clinical indications for tests and that he would not turn down any test that was clinically necessary for good patient care. If lower cost tests can give the same clinical outcome, then he believes that money saved could be better spent on providing more care for other patients. No one at the medical center tracked and trended the number of cases the COS reviewed for clinical appropriateness or the number of requests approved or denied. There was no mechanism for a secondary review of denials.

We concluded the utilization review process in place is appropriate. However, there should be an appeal process for providers who disagree with decisions. Quality managers should develop a monitor to track the appropriateness of tests that providers order. The COS can then use that data to educate staff and improve patient care.

5. Conclusion

The medical center leadership instituted administrative changes at the EOPC in an effort to facilitate greater compliance with VHA policies and regulations. Some EOPC staff members do not support the changes. Management is authorized to make changes to ensure patient safety, quality of care, and compliance with VHA guidelines and procedures. New EOPC managers are in place and need time to recruit and fill vacant positions, provide effective leadership, and improve communication internally and with the medical center.

6. Recommendations

We recommended that the VISN Director require that the Medical Center Director:

Recommended Improvement Action 1. Evaluate the current utilization review process and establish an appeal process when clinicians disagree with decisions.

Recommended Improvement Action 2. Establish a performance improvement monitor to trend the clinical appropriateness of providers' orders for radiographic tests that require upper-level approval.

7. Medical Center and VISN Directors' Comments

The Marion VA Medical Center Director and the VISN 15 Director concur with the report findings and recommendations.

8. Assistant Inspector General for Healthcare Inspections 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 completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

Appendix A

Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 25, 2006

From: Director, Veterans Integrated Service Network (10N15)

Subject: **Alleged Hostile Work Environment and Quality of Care Issues**

Evansville Outpatient Clinic, Evansville, Indiana

To: Office of Inspector General

I have reviewed and concur with the report findings and the action plan as outlined by the Marion, IL VAMC.

PETER L. ALMENOFF, MD, FCCP

Appendix B

Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 22, 2006

From: Director, Marion, IL VA Medical Center (657A5/00)

Subject: **Alleged Hostile Work Environment and Quality of Care Issues**

Evansville Outpatient Clinic, Evansville, Indiana

To: Assistant Inspector General for Healthcare Inspections

1. We appreciate the opportunity to comment on the inspection report concerning the Evansville Outpatient Clinic in Evansville, Indiana.

2. We concur with the report's findings and recommendations. Specific corrective actions, along with target completion dates, have been included.

3. We appreciate the thoroughness of the review, professionalism of the inspection team and their dedication towards ensuring the highest quality health care standards are maintained for veterans.

4. Should you have any questions or concerns, please do not hesitate to contact me at 618-993-4100.

(original signed by:)

ROBERT D. MORREL

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 1. Evaluate the current utilization review process and establish an appeal process when clinicians disagree with decisions.

Concur **Target Completion Date:** June 30, 2006

The Chief of Staff and Professional Standards Board will examine the utilization review process and establish an appeal process for clinical disagreements.

Recommended Improvement Action 2. Establish a performance improvement monitor to trend the clinical appropriateness of providers' orders.

Concur **Target Completion Date:** June 30, 2006

The Chief of Staff will establish a performance monitor to trend the appropriateness of provider orders requiring higher level authorization.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Virginia Solana, Director Kansas City Regional Office of Healthcare Inspections (816) 426-2016
Acknowledgments	Reba Ransom Dorothy Duncan

Appendix D

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