Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Management Decisions Impacting Patient Care and Work Environment Oscar G. Johnson VA Medical Center Iron Mountain, Michigan

Report No. 09-02470-61 **January 13, 2010**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations

Telephone: 1-800-488-8244 between 8:30AM and 4PM Eastern Time, Monday through Friday, excluding Federal holidays

E-Mail: vaoighotline@va.gov

Contents

Executive Summary

At the request of Chairman Bob Filner, House Committee on Veterans' Affairs, the Office of Inspector General, Office of Healthcare Inspections reviewed the validity of multiple allegations regarding decisions impacting patient care and work environment at the Oscar G. Johnson VA Medical Center in Iron Mountain, MI.

Certain allegations related to human resources concerns; physician recruitment and pay, intimidation, and perceptions of preferential treatment were not addressed and were beyond the scope of an OHI review. The remaining allegations were grouped into the following themes, as presented by the complainant:

- Management arrogance affects patient care and staff morale adversely.
- Intimidation.
- Emergency room issues.
- Inconsistent and frequent changes.

Three of the allegations resulted in recommendations to the Veterans Integrated Service Network and Medical Center Directors. We recommended that actions be taken to reduce the scanning backlog and establish a process to assure timely entry of significant information in patients' electronic medical records. We recommended that managers initiate a review of registered nurse staffing to ensure coverage of the Emergency Department and Nursing Officer of the Day. We also recommended that the Medical Center Director communicates, orally and in writing, organizational changes to all employees and that administrative supervisory lines are clearly written and effected in official personnel actions.

Management agreed with the findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

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

TO: Director, VA Great Lakes Health Care System (10N12)

SUBJECT: Healthcare Inspection – Alleged Management Decisions Impacting Patient Care and Work Environment, Oscar G. Johnson VA Medical Center, Iron Mountain, Michigan

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) conducted an inspection at the Oscar G. Johnson VA Medical Center (the medical center) in Iron Mountain, Michigan. The inspection was initially at the request of Congressman Bob Filner, Chairman of the House Committee on Veterans' Affairs and involves multiple allegations concerning the medical center management. The purpose of the inspection was to determine the validity of the allegations.

Background

Located in Iron Mountain, Michigan, the medical center is part of Veterans Integrated Service Network (VISN) 12 and provides primary and secondary level care through a broad range of inpatient and outpatient health care services. The medical center has 17 hospital beds and 40 community living center (CLC) beds. Outpatient care is also provided at six community based outpatient clinics (CBOCs) in Hancock, Ironwood, Marquette, Menominee, and Sault Sainte Marie, MI, and in Rhinelander, WI. The medical center serves a veteran population of about 56,000 throughout 15 counties in Michigan and 8 counties in northeastern Wisconsin.

The complainant provided multiple allegations with examples as part of a number of general themes as follows:

1. Management arrogance affects patient care and staff morale adversely. Examples included:

    a. Removing paper charts from the CBOCs without proper planning and training of clinical providers and nursing staff.

b. Sudden closure of the intensive care unit (ICU) without providing clear reason or prior notification to staff or patients.

c. Reopening the ICU after 3 months with significantly more staff and a decrease in beds from six to four.

d. A Substance Abuse Treatment Unit (SATU) had been discussed multiple times in the past few years, funding was obtained, but this was never accomplished.

e. Moving a dietitian into a hospitalist workroom in the CLC without courtesy notification to the hospitalists, provisions for an alternative work space, or area for storage of patient information.

f. Stopping the printing of abnormal radiology reports in Primary Care without informing clinical providers.

g. Institution of a "no cancellation policy" resulting in patients being evaluated by multiple providers, with no continuity of care.

h. All responsibility for inpatient medication reconciliation is being placed on hospitalists, despite repeated requests for additional inpatient pharmacists.

i. Placing all fee basis consults on "administrative hold" for several months while creating more obstacles to get these tests and important services to veterans. Only those patients who need the tests emergently are being approved, resulting in an unfair delay to veterans' care. Specific consults mentioned include sleep apnea, electromyography (EMG),[1] cardiology, pulmonary, and chiropractic.

j. Nurses were given overtime for completing influenza clinical reminders to improve the VA score and not patient care.

k. Management's belief that the hospitalist program is a failure, resulting in the potential decision to close inpatient services again.

l. Replacement of Emergency On Duty (OD) list with back-up Medical Officer of the Day (MOD) list, even though Emergency OD list worked successfully for the past 15 years.

m. Hundreds of patients are without an assigned primary care provider (PCP).

n. Front door project called for 3-feet-wide doors, not accommodating wide wheelchairs as recommended by the Americans with Disabilities Act (ADA).

2. Intimidation. Examples included:

a. Physicians placed on back-up MOD call during approved vacation time.

[1] A technique for evaluating and recording the activation signal of muscles.

b. Staff reluctant to complete the employee survey for fear of reprisal, as the employee can be easily identified with a specific identification number.

c. A senior manager inquired if a provider of a specific culture was a member of the American Federation of Government Employees (AFGE) (commonly known as an employee union).

3. Emergency Room (ER) Issues. Examples included:

a. Built with no patient privacy.

b. Lack of triage protocols.

c. No estimated wait time for non-emergent and non-urgent problems.

d. Permanently understaffed.

e. Untrained nurses forced to work in the ER.

f. Untrained providers forced to cover in the ER.

g. Nurses required to perform clerical responsibilities, as administration was not able to provide a clerk for the ER.

4. Inconsistent and Frequent Changes. Examples included:

a. Primary Care reorganization has occurred twice every year for the last 2 years.

b. Hospitalists' tours of duty have changed multiple times in the last few months without informing involved providers.

c. ER versus Urgent Care (UC). Treatment room changed from ER to UC and changed back again several times. The Chief of Staff informed that the treatment room has been an ER for the last few months, but the services are still billed as an UC.

d. High turnover of administrators. The medical center is a "stepping stone and most of the Directors and Associate Directors stay for 3–4 years and then move on."

e. High turnover of providers from factors like location, climate, and work environment, leading to patients evaluated by multiple providers with limited continuity of care and several patients with no assigned provider.

Scope and Methodology

We conducted a preliminary site visit at the medical center on July 21, 2009, and completed our full onsite inspection August 18–21. We reviewed pertinent documents which included Veterans Health Administration (VHA) and medical center policies and procedures, Joint Commission standards, committee minutes, quality management documents, and selected administrative and related management documents.

Certain allegations presented by the complainant were beyond the scope of an OHI review. These allegations were related to human resources concerns, physician recruitment and pay, intimidation, and perceptions of preferential treatment, and would more appropriately be managed through other non-OIG entities. We focused our efforts on those allegations that were directly related to the quality of patient care and the work environment.

We initially contacted the complainant by telephone and requested supportive documentation. We also interviewed the complainant while onsite and again requested that the complainant provide documentation to support and clarify the allegations. Further, we made a third request for documentation while onsite, as well as a fourth reminder during a telephone contact with the complainant after our onsite visit. The complainant provided the OHI team with a listing of individuals perceived as most knowledgeable regarding each allegation. We interviewed many of the recommended individuals and others per allegation. If we noted consistencies in interviews, we determined whether additional interviews were warranted for each allegation. During the course of this inspection, we interviewed VISN 12 and medical center senior managers and other clinical and administrative staff.

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

Inspection Results

Issue 1: Management Arrogance is Affecting Patient Care and Staff Morale Adversely

Allegation (a): ***Removing paper charts from the CBOCs without proper planning and training of clinical providers and nursing staff.***

We substantiated that a management decision was made to remove paper charts from the CBOCs. However, we did not substantiate that there was a lack of planning or training of clinical staff. Following an incident regarding a potential breach of sensitive patient information in June 2007, managers investigated the incident and provided an issue brief to VHA. One of the recommendations detailed in this investigation was for all medical records at the CBOC locations to be brought to the medical center's main file room. A new process for scanning medical records was to be developed, in addition to a service-level agreement to ensure compliance. For those paper records, such as non-VA test results brought to the CBOC by a patient, the provider reviews the documents, determines if the documents should be scanned for inclusion in the medical record and notates this accordingly, and documents any pertinent information in the patient's medical record. All CBOC locations have computers available for clinical staff to access patients' electronic medical records through the computerized patient record system (CPRS). Additionally, the medical center recognized that reduction of paper records

would increase patient safety, ensure privacy, and allow others immediate access to documents through CPRS. All clinical staff received training on CPRS use. In preparation for the CBOCs' paper record transition, additional CPRS training was provided onsite. The medical center also instituted a process for CBOC staff to request copies of paper record extracts when needed.

During interviews related to this allegation, we learned that the medical center had a significant backlog of approximately 160 inches of documentation waiting for scanning. Results are prioritized, and the high priority documents are scanned first, with computer view alerts sent to providers. Managers acknowledged that staffing issues have contributed to the backlog.

Recommendation 1: We recommended that the VISN Director ensure that the Medical Center Director takes immediate steps to reduce the scanning backlog and establish a process to assure timely entry of significant information in patients' electronic medical records.

Allegation (b): ***Sudden closure of the ICU without providing clear reason or prior notification to staff or patients.***

We substantiated the allegation. Closure of the medical center's ICU occurred over the 2008 Labor Day holiday weekend and was mandated by the former VISN 12 Director following multiple reviews of inpatient services. Significant gaps were identified in the consistency of ICU care during weekends, holidays, evenings, and night tours of duty. There were a limited number of internal medicine providers, and the medical center had limited success in recruiting qualified physicians. It was also identified that the Emergency Department (ED)[2] physician was responsible for inpatient and ICU coverage, in addition to the ED, which was contrary to a mandate from the Deputy Undersecretary for Health for Operations and Management (DUSHOM). After ongoing strategic discussions with medical center leadership, the former VISN 12 Chief Medical Officer (CMO) recommended in a memorandum to the Medical Center Director through the former VISN 12 Director on September 2, 2008, "Temporary diversion of inpatient ICU care until such time a recruitment of a complete cadre of board certified appropriate hospitalists and an appropriate ICU Chief can be in place to ensure an appropriate level of physician coverage is available at all times." The medical center maintained closure of the ICU until early January 2009.

Managers acknowledged that the ICU closure was abrupt to staff. Notifications were provided to staff that were on duty on the Friday prior to the closure, and managers also telephoned staff to alert them of this directive and to provide further guidance. Managers also sent e-mail messages and further updates.

[2] Emergency Department (ED) and Emergency Room are used interchangeably in this report. Both describe the same area.

Allegation (c): ***Reopening the ICU after 3 months with significantly more staff and a decrease in beds from six to four.***

We did not substantiate that there was a significant increase in staff after the ICU reopened. Managers reported no increase in staffing upon the reopening of the ICU. Managers had taken steps to implement a hospitalist program, and aggressive recruitment of board certified internal medicine physicians was continuing. We compared information from the Gains and Losses Sheets[3] from dates prior to the closure with dates after the ICU reopened. The medical center reported five authorized beds (4 Medical ICU, and 1 Surgical ICU); the same as the operating beds, both prior to closure and after reopening. Managers reported that they were directed by the VISN to limit capacity to four patients when they reopened the ICU.

Allegation (d): ***An SATU had been discussed multiple times in the past few years, funding was obtained, but this was never accomplished.***

We did not substantiate the allegation. There was not a request or approval for a SATU. The medical center operated a Psychosocial Residential Rehabilitation Treatment Program (PRRTP) from 2000–2003. The program provided beds for general mental health, substance use disorders, and Post-Traumatic Stress Disorder care. The PRRTP was a 24-hour, 7-days per week program with veterans residing onsite. Analysis of the program effectiveness was conducted and found that the average number of veterans per full-time employee was low, the mental health veterans served by the PRRTP beds consumed approximately 30 percent of all mental health resources, and 16–20 percent of the veterans in the PRRTP were outpatients who commuted to the medical center for the program.

On August 26, 2003, the medical center and VISN developed a proposal to close the PRRTP based on lack of demand locally to maintain a supportable program with enough patient involvement to maintain staff competencies and ensure patient safety. The PRRTP resources were devoted to intensive outpatient substance abuse services at the medical center and to purchase needed services close to the homes of addicted veterans. Additionally, collaborative efforts were established with the Milwaukee and Tomah VA facilities to provide residential treatment for Iron Mountain veterans as needed.

An intensive outpatient substance abuse treatment program has been established at the medical center, needed services are provided in the community where veterans reside, and residential treatment is available at VA facilities within the network.

During early 2008 there were discussions about reopening the PRRTP; however, this did not come to fruition due to funding and staffing to support the program.

[3] A daily report generated to include patient admissions, transfers, discharges, and bed status.

Allegation (e): ***Moving a dietitian into a hospitalist workroom in the CLC without courtesy notification to the hospitalists, provisions for an alternative work space, or area for storage of patient information.***

We did not substantiate the allegation. A dietitian was temporarily relocated to the CLC for approximately 2 months pending a Primary Care Clinic office assignment. This dietitian was assigned to a vacant office, room 1144, which was designated as a shared CLC physician office. In addition to a hospitalist work space on the medical center's fourth floor, hospitalists who rotated CLC rehabilitation patient coverage shared work space in another office that included two work stations with computers. This area was also used by the CLC's nurse practitioner. Employees were not asked to move or inconvenienced by the temporary office assignment for the dietitian's use.

Allegation (f): ***Stopping the printing of abnormal radiology reports in Primary Care without informing the providers.***

We substantiated that a management decision was made to discontinue manual printing of abnormal radiology reports. We could not substantiate or refute that providers were given ample notice regarding this change. The decision to stop printing the reports was made in 2007. The past practice was to manually print all radiology reports, including abnormal reports, and deliver them to the Primary Care Clinic. Nursing staff were required to sort and separate reports for delivery to individual providers. This process was time consuming and involved multiple personnel. Managers assessed the potential for compromise in patient safety due to missed abnormal reports and the potential for compromise in patient privacy due to the printed sensitive information. It was determined that the CPRS provider alert function would be more safe and secure than the printed method of notification. We were not able to confirm whether sufficient notice was provided to those clinical staff involved at the time this decision was made. However, staff interviewed reported that the provider alert function in CPRS is the most effective method for communicating abnormal results.

Allegation (g): ***Institution of a "no cancellation policy" resulting in patients being evaluated by multiple providers, with no continuity of care.***

We did not substantiate the allegation. In an effort to minimize patient cancellations and ensure continuity of care, the Chief of Staff instituted a policy whereby providers must schedule planned absences well in advance of the event. Medical center policy requires, "Providers should schedule planned absences for conferences and vacations as far in advance as possible so schedule changes can be made before [patient] appointments are actually scheduled." Further, the policy requires providers to submit a clinic cancellation request more than 90 days in advance of the clinic date, routing the request through the Service Chief, if the request involves more than two dates. The provider and Service Chief collaborate to identify alternative times for patients to be seen or to identify staff to cover in the provider's absence. The medical center also clarified expectations regarding

emergency cancellations, defined as less than 30 days and greater than 1 day prior to the clinic date, as well as emergency cancellations on the clinic date or day prior.

Allegation (h): ***All responsibility for inpatient medication reconciliation is being placed on hospitalists, despite repeated requests for additional inpatient pharmacists.***

We did not substantiate the allegation. Joint Commission's National Patient Safety Goal 8 requires that patient medications are accurately and completely reconciled across the continuum of care. This goal includes the following standards:

- A process exists for comparing the patient's current medications with those ordered for the patient while under the care of the organization.

- When a patient is referred to or transferred from one organization to another, the complete and reconciled list of medications is communicated to the next provider of service, and the communication is documented. Alternatively, when a patient leaves the organization's care to go directly to his or her home, the complete and reconciled list of medications is provided to the patient's known primary care provider, the original referring provider, or a known next provider of service.

- When a patient leaves the organization's care, a complete and reconciled list of the patient's medications is provided directly to the patient and, as needed, the family, and the list is explained to the patient and/or family.

- In settings where medications are used minimally, or prescribed for a short duration, modified medication reconciliation processes are performed.

The Chief of Pharmacy Service acknowledged that medication reconciliation is a collaborative effort shared by clerks, nurses, pharmacists, and providers. Medical center policy states that providers have the ultimate responsibility for medication reconciliation. This policy tasks the Pharmacy and Therapeutics Committee with the responsibility for reviewing and evaluating medication reconciliation compliance, monitoring data regarding the process, and initiating corrective actions. A Medication Reconciliation Charter Team was established, and the team reports their progress during the medical center's Quality Council meetings. Additionally, medication reconciliation successes and challenges are reported to the DUSHOM as part of VHA's 5 Million Lives Campaign.[4] One of the 12 interventions of this campaign is: "Prevent adverse drug events by reconciling patient medications at every transition point in care." We reviewed the medical center's report to the DUSHOM for quarters 1, 2, and 3 of fiscal year (FY) 2009.

[4] Institute for Healthcare Improvement's voluntary initiative promoting the adoption of 12 improvements in care that can save lives and reduce patient injuries.

Quarter 1 notable actions included:

> "Interdisciplinary involvement and new software has allowed the facility to meet the goal of providing medication education sheets to patients. This list has expanded to include medications from other VAs in addition to non-VA medications thus prevention errors of omission with admission and duplication between facilities. Planned Actions: Further review shows one locum tenens[5] hospitalist needs additional education on both monitors as his discharges are reflected in the low numbers."

Quarter 2 notable actions included:

> "Use of standardized list. Standard Operating Procedure for outpatient medication reconciliation. Revision of outpatient medication reconciliation statistics. Planned Actions: Additional training to Primary Care."

Quarter 3 notable actions included:

> "Medication reconciliation template for Primary Care is being developed to standardize documentation, provide better reporting, and allow group to identify educational needs. Planned Actions: Template development and continued education to providers."

While the Chief of Pharmacy Service reported ongoing challenges in recruiting pharmacists to the Iron Mountain area, he noted that aggressive medication reconciliation efforts are in place and closely monitored.

Allegation (i): ***Placing all fee basis consults on "administrative hold" for several months while creating more obstacles to get these tests and important services to veterans. Only those patients who need the tests emergently are being approved, resulting in an unfair delay to veterans' care. Specific consults include sleep apnea, EMG, cardiology, pulmonary, and chiropractic.***

We substantiated that there has been greater scrutiny of fee basis services as part of an effort to be fiscally responsible. The medical center has also reduced the need for some fee basis services based on successful recruitment of qualified specialists. During the 12-month period prior to our onsite review, the medical center recruited professionals in cardiology, neurology (including EMG and sleep study), chiropractic, and general surgery. Senior managers reported that providing these services onsite by the recruited specialists was optimal. Emergent and urgent consults in all specialties continued to be referred to appropriate sources. For example, we asked the medical center to provide statistics for cardiology consults during the period January 1 to July 17, 2009. Twenty-two fee basis consults were processed at non-VA facilities. The Madison VA facility

[5] Physicians who contract with the medical center, usually on a short-term basis.

processed 14 consults; while the Milwaukee VA facility processed 115 consults. Additionally, the medical center utilizes the Milwaukee VA facility for tele-pulmonary clinic services. Senior managers also evaluated the use of fee basis chiropractic care because they identified a significant number of non-service-connected veterans who were receiving these services. During the same period, 79 chiropractic care episodes were provided through fee basis. The Chief of Staff determined that patients who had been provided ongoing fee basis chiropractic care required reevaluation by physical therapy, with recommendations to either continue chiropractic care as appropriate, or change the treatment plan based on the assessment. The Chief of Staff also opted to not discontinue chiropractic care for those service-connected veterans who had been on this regime for a significant time.

We requested a summary of patient complaints related to this change in chiropractic care from October 2008 until our onsite visit. The Patient Advocate logged four complaints from patients who had been receiving chiropractic care for some time; however, they were informed that they would be receiving a physical therapy evaluation. Additionally, the medical center had successfully recruited a chiropractor, so the medical center will be providing these services onsite once the provider is on duty.

Allegation (j): ***Nurses were given overtime for completing influenza clinical reminders to improve the VA score and not patient care.***

We substantiated the allegation that nurses were given overtime, but not to improve the VA score, but to ensure patients were given opportunities to receive influenza vaccines. The Associate Director for Patient Care Services informed us that overtime was never mandated, many nurses volunteered on-duty time to assist with a "flu campaign," and very little overtime was used. VHA established FY 2009 performance measures for influenza vaccine immunizations for veterans in targeted age ranges. The performance measures are evidence-based measures to improve patient care, and these include target percentages as goals. The medical center established a "flu campaign" committee who developed informational flyers about flu and how to receive the vaccine. A form was also developed for patient use to report the receipt of a flu vaccine at a non-VA facility. The committee action plan included having an e-mail message sent to all nurses requesting volunteers with the goal to recruit one nurse per CBOC location. We interviewed nurse managers who reported that overtime was authorized for nurses who volunteered, however there was little overtime used. As a result of these efforts, the medical center exceeded the performance measure targets during quarters 3 and 4 of FY 2009.

Allegation (k): ***Management's belief that the hospitalist program is a failure, resulting in the potential decision to close inpatient services again.***

We did not substantiate the allegation. We interviewed senior managers regarding the hospitalist program. Managers reported the hospitalist program as successful, and in fact,

purposeful decisions have been made to augment this program. As a result of an external site visit that focused on inpatient services, the former VISN 12 CMO suggested a number of actions to address the identified coverage issues for the inpatient care units and ICU. The CMO recommended in a September 2, 2008, memorandum to the Medical Center Director through the former VISN 12 Director the temporary diversion of inpatient ICU care until such time a recruitment of a complete cadre of board certified hospitalists and an ICU Chief was in place to ensure an appropriate level of physician coverage at all times. The CMO also detailed additional actions in a September 3, 2008, memorandum to the medical center's Chief of Staff and Associate Director for Patient Care Services. The memorandum cited the inpatient hospital coverage, described as "recently changed to a hybrid hospitalist model." The CMO recognized the increasing level of acuity of patients and the challenges in recruiting board certified internal medicine providers to the area. Three providers initially volunteered to take on the role of hospitalists, including two internal medicine physicians and one family practice physician. The CMO stated in the memorandum, "While the use of mid-level providers currently under recruitment is a potential solution given the acuity of inpatients currently receiving care, an expansion of the hospitalist program would be a necessary component of this plan." The CMO also detailed problems with the current hospitalists providing coverage for the ED. Managers assessed that the hospitalists should take a role in ED coverage; however, the DUSHOM guidance[6] requires that this function only be provided by dedicated physicians, not mid-level providers, such as nurse practitioners or physician assistants.

Allegation (l): ***Replacement of Emergency OD list with back-up MOD list even though Emergency OD list worked successfully for the past 15 years***.

We substantiated that managers made a decision to change the way emergency back-up was managed. The Chief of Staff reported that the medical center previously maintained a listing of providers for call back during emergencies, such as occasions when a provider cannot report to duty due to illness. The procedure was for the Administrative Officer of the Day (AOD) to start at the top of the list, continuing to work down the list until someone agreed to come in. To ensure patient safety, the Chief of Staff instituted a fixed call back schedule. Providers are now assigned on call dates, with the expectation to be reachable by phone and able to report to the medical center within 1 hour of receiving the call. The Chief of Staff also allowed for providers to trade on call duty if their scheduled date was problematic.

Allegation (m): ***Hundreds of patients are without an assigned PCP***.

We substantiated the allegation. Managers acknowledged that there has been turnover in providers resulting in patients who may not have yet been assigned a new provider.

[6] DUSHOM memorandum to Network Directors, "Clarification of Provider Staffing Requirements for Emergency Departments and Urgent Care Clinics in VHA," April 18, 2008.

Although all of the patients were receiving ongoing care, at the time of our onsite visit, there were approximately 257 patients who did not have an assigned PCP. Additionally, the medical center has supplemented staffing through the use of locum tenens contractors, although the contracts may be for only 3–6 months at a time. The medical center established a panel size of 1,200 patients for full-time physicians and 900 patients for full-time mid-level providers. The medical center was initiating a process to notify those patients whose provider was no longer there and to notify them of their new provider.

Allegation (n): ***Front door project called for 3-feet-wide doors, not accommodating wide wheelchairs as recommended by the ADA.***

We did not substantiate the allegation. Section 404.2.3 of the ADA requires that door openings shall provide a clear width of 32 inches (815 mm) minimum. The front door project began December 22 and concluded on December 31, 2008. A standard 36-inch swinging door with manual push button operation was installed. The doors were designed to be compliant with all applicable codes.

In early 2009, complaints surfaced that patients with wide wheelchairs had difficulty using the entrance. The medical center contacted the VA's contracting officer and requested additional funding to modify the doors. The original contracted company was contacted to remove the installed 36-inch doors and replace them with 48-inch doors. The second door installation project began May 1 and concluded May 6, 2009. The original 36-inch doors were retained by the medical center for use in a future project.

Issue 2: Intimidation

Allegation (a): ***Physicians placed on back-up MOD call during approved vacation time.***

We could not substantiate or refute the allegation. We interviewed the employee responsible for creating the provider schedules. The employee described challenges in scheduling, especially ensuring appropriate coverage around planned absences. For example, 17 changes were made to the August 2009 schedule prior to it being posted. The Chief of Staff reported that one provider alerted him that they were scheduled for extra on-call days. This was identified as an error and corrected. However, we were unable to identify a specific provider whose schedule was in error. Managers' intent is to schedule providers fairly and equitably and to correct errors when they are discovered.

Allegation (b): ***Staff reluctant to complete the employee survey for fear of reprisal, as the employee can be easily identified with a specific identification number.***

We did not substantiate the allegation. We interviewed managers and employees most knowledgeable about the All Employee Survey to determine if survey responses could be linked to an individual. It was confirmed that this was not possible. Employees in

services with 10 employees or less were grouped with other smaller services. The medical center's employee response rate has been tracked. In 2007, there was a 91 percent response rate. Response rates for 2008 and 2009 were 79 percent and 83 percent respectively. Managers have taken appropriate steps to identify areas for improvement based on survey responses.

Allegation (c): ***A senior manager inquired if a provider of a specific culture was a member of the AFGE.***

We could not substantiate or refute the allegation. We conducted interviews with a significant number of employees who were members of the local AFGE, as well as those who were not. None of the individuals interviewed reported ever personally hearing or having others relay information about inquiries made regarding whether or not any particular provider was an AFGE member. Senior managers are generally not aware of those employees who are AFGE members, unless those employees are involved in an action where there is AFGE presence.

Issue 3: Emergency Room Issues

Allegation (a): ***Built with no patient privacy.***

We did not substantiate the allegation. The ED has five bays separated by walls and a privacy curtain in front of each. A total of six beds are utilized in the ED, and one has been designated to accommodate female veterans. Staff told us they maintain patient privacy by talking in a low volume and keeping privacy curtains closed. We visited this area several times during the day and observed patients and staff. We did not find visual or auditory privacy issues. Privacy curtains were in use as needed, and staff spoke quietly while discussing medical treatment and care.

Allegation (b): ***Lack of triage protocols.***

We did not substantiate the allegation. Patients presenting to the ED for treatment are triaged by a registered nurse (RN) who utilizes the Emergency Severity Index (ESI). The ESI has 5 levels which identifies the process of how patient care will be delivered. Level 1 is emergent; level 2 is urgent; level 3 is acute, level 4 is routine, and level 5 is non-urgent. According to medical center policy, patients triaged at levels 4 or 5 will be seen by a provider with the most immediate availability in Primary Care. If the patient does not have an assigned PCP or their PCP is stationed at a CBOC, they will be seen in a Primary Care Clinic with open appointments or availability due to patients who did not show for scheduled appointments. At the time of our inspection, a patient presenting to the ER enters an unstaffed room where there is signage directing the patient to pick up the telephone for assistance. Staff noted that at times patients do not call, but prefer to wait for a staff member to enter the room. The new ED manager had assessed patient

flow and identified this as problematic. Process changes were already underway at the time of our inspection.

Allegation (c): ***No estimated wait time for non-emergent and non-urgent problems.***

We did not substantiate the allegation. Managers have studied wait times for ED patients. The following table shows ED patient volume and wait times.

Date	Number of Patients Presenting to the ED	Number of Patients Whose Wait Extended Beyond 6 Hours
5/1/07–4/30/08	3,560	22
5/1/08–4/30/09	3,343	21
5/1/09–6/30/09	667	4

Allegation (d): ***Permanently understaffed nurses.***

We did not substantiate the allegation; however, we identified that the RN covering the ED during weekends, holidays, evenings, and nights also has a collateral duty as Nursing Officer of the Day (NOD). The ED is typically staffed Monday through Friday with 2 RNs on the day shift, 1 RN on the evening shift, and 1 RN on the night shift. Weekend and holiday coverage generally consists of 1 RN per shift. If additional coverage is needed, RNs from the ICU or acute care unit may be requested to assist in the ED. NOD duties involve other administrative functions that may require the RN to leave the immediate ED area. This may result in a situation where there is no RN availability when a critical need arises in the ED.

Recommendation 2: We recommended that the VISN Director ensure that the Medical Center Director requires a review of RN staffing to ensure proper coverage of the ED at all times as well as staffing to support NOD duties**.**

Allegation (e): ***Untrained nurses forced to work in the ER.***

We did not substantiate the allegation. RNs are assigned to Primary Care Service and complete an ED rotation every 8–9 weeks. We reviewed vacancy announcements for Primary Care RN positions, and these announcements include the expectation of providing coverage in the ED. RNs are orientated to the ED, and this training is documented. New RNs are also partnered with experienced staff. RN competency is assessed annually and includes duties that are consistent with RNs working in critical care. All RNs who work in the ED are required to maintain Advanced Cardiac Life

Support (ACLS) certification. Due to the medical center's generally low patient volume, low acuity level, and non-acceptance of trauma cases, management recognized the need for additional training for staff to maintain critical care/ED-level competencies. Managers instituted staff rotation at the North Chicago VA Medical Center ED, participation in a local trauma nurse core curriculum, and telemetry training coordinated by an ICU RN.

Allegation (f): ***Untrained providers forced to cover in the ER***.

We did not substantiate the allegation. VHA requires that a dedicated physician must be present and available at all times in the ED. The physician should have no other responsibilities outside of the ED. When the medical center instituted the hospitalist program, two internal medicine physicians and one family practice physician volunteered for this role. Due to limited physician staffing, the Chief of Staff required that the hospitalists assume ED coverage, among other patient care assignments within the medical center. The medical center recognized they were not in compliance with VHA requirements to have a dedicated physician in the ED at all times. This has been corrected, and physician coverage has also been augmented as a result of recent successful recruitment efforts. Physicians who cover in the ED are credentialed and privileged through the medical center's Professional Standards Board. Physicians who cover the ED must maintain ACLS certification.

Allegation (g): ***Nurses required to perform clerical responsibilities, as administration was not able to provide a clerk for the ER.***

We substantiated the allegation. A clerk is not assigned to the ED. Management told us they would like to provide administrative support to every area of the medical center, but had to make difficult choices to prioritize the clerical resources. Nursing staff is responsible for performing clerical duties and answering the telephone during the day shift. The AOD is called to provide assistance during the weekends, holidays, and evening tours.

Issue 4: Inconsistent and Frequent Changes

Allegation (a): ***Primary Care reorganization has occurred twice every year for the last 2 years.***

We substantiated the allegation. Managers confirm that there have been transitions in Primary Care leadership. In fact, we interviewed a manager who was unable to definitively say who his supervisor was. Employees interviewed reported that there have been many changes in the organization, and that the changes have not always been effectively communicated. Staff at all levels reported that there was a need for improved communication by senior managers. The Medical Center Director did inform us that he holds regularly scheduled VISN and Town Hall forums, and Director Staff, Quality

Council, and Clinical Executive Board meetings. There are many open invitational venues to keep employees apprised of new information. Additionally, information is posted on the medical center's intranet homepage and email is sent to all employees regarding new initiatives and changes. Documents show that though invited, there is absent membership for labor/management employee representatives in multiple management meetings and standing committees.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director communicates, orally and in writing, organizational changes to all employees and that administrative supervisory lines are clearly written and effected in official personnel actions.

Allegation (b): ***Hospitalists' tour of duty has changed multiple times in the last few months without informing involved providers.***

We substantiated that there have been changes in the hospitalists' tours of duty, but did not substantiate that these were made without proper notice. We interviewed providers and administrative staff who were knowledgeable of the changes. Staff reported the schedule changed many times and needed to be frequently checked to ensure tours of duty were not inadvertently missed. Providers were able to view the schedule electronically.

Allegation (c): ***ER versus UC. Treatment room changed from ER to UC and changed back again several times. The Chief of Staff informed that treatment room has been ER for last few months, but the services are still billed as an UC.***

We substantiated the allegation. VHA policy requires that in facilities having medical/surgical beds and an ICU, there is a dedicated unit to provide unscheduled access to emergency care each day, 24 hours a day.[7] During an external audit in 2000, it was determined that the medical center's complexity level did not support having an ED. The ED was transitioned to an UC Clinic for 6 years. In late 2006, the medical center transitioned back to ED status.

In 2008, the VISN conducted a review of the inpatient services and found that staff levels were not appropriate to support the ICU. Actions were implemented for the temporary diversion of inpatient ICU care until such time a recruitment of significant physicians occurred. During this time, the ED was reduced to an UC Clinic.

In early 2009, appropriate staffing levels were obtained, and the UC Clinic was transitioned back to an ED. Specific billing codes are designated for care provided in the ED and UC Clinic. Administrative staff were responsible for converting the codes to reflect the level of care provided in the ED.

[7] VHA Directive 2006–051, *Standards for Nomenclature and Operations in VHA Facilities Emergency Departments,* September 15, 2006.

Allegation (d): ***High turnover of Administrators. The medical center is a "stepping stone and most of the Directors and Associate Directors stay for 3–4 years and move on."***

We substantiated the allegation. Since 2000, the medical center has had three Directors, three Associate Directors, two Associate Directors for Nursing and Patient Care Services, and three Chiefs of Staff. Traditionally in VHA, senior managers might begin their careers in smaller or less complex medical facilities and later transfer to more complex facilities. Managers might also be asked by VHA officials to assume more responsible leadership roles and have the right to consider and pursue other career options.

Allegation (e): ***High turnover of providers from factors like location, climate, and work environment, leading to patients evaluated by multiple providers with limited continuity of care and several patients with no assigned provider.***

We substantiated the allegation. From July 1, 2008, to July 16, 2009, the medical center hired 25 physicians and 4 nurse practitioners. Managers told us that geographically, it is difficult to recruit providers to the area and once the providers are on staff, it is also difficult to retain them. Seven locum tenens contractors were approved on time-limited appointments. During this same period, 11 physicians left and the circumstances for their departure were as follows: 3 resigned for family reasons, 3 resigned for administrative matters, 1 resigned to seek another professional opportunity, 1 resigned due to new expectations of duties by the Chief of Staff, and 3 gave no reason.

We were told that some patients were not assigned to providers due to the recruitment issues. Locum tenens were hired during the interim, and some patients were seen by multiple providers. As new providers were hired, patients who were unassigned were added to the panels. The new Chief of Staff conducted an inquiry and found that the panel size for existing providers was not being maximized. VA recommends that PCPs have a panel size of 1,200 patients and mid-level providers have 900 patients. Administrative changes were made to increase panel sizes to full capacity. At the time of our review, there were approximately 257 patients who were not assigned PCPs. Because of a shortage of providers and a lack of a group of consistent physicians, the patients received care but were seen by different providers. We were informed that there were between 200-300 patients that might not have had an assigned provider during the 3 months prior to our onsite inspection. Various clinical and administrative staff were currently working on ensuring that all unassigned patients have assigned PCPs. This includes an action plan whereby staff are assigning patients based on provider panels, patient preferences, and notifying patients by mail.

Conclusions

Management made decisions to improve patient care in many areas, but changes were not always well received by others. While we did find some opportunities for improvement

as outlined in our recommendations, we did not conclude that management decisions negatively impacted patient care or the work environment.

Comments

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable corrective actions. (See Appendixes A and B, pages 19–23, for the full text of the Directors' comments.) We will follow up on the planned actions until they are complete.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 15, 2009

From: Director, VA Great Lakes Health Care Network (10N12)

Subject: **Healthcare Inspection – Alleged Management Decisions Impacting Patient Care and Work Environment, Oscar G. Johnson VA Medical Center, Iron Mountain, Michigan**

To: Director, Chicago Office of Healthcare Inspections (54CH)

1. VISN 12 is committed to a culture of continuous improvement via ongoing collaboration and transparent partnerships with external review bodies within VISN 12 medical centers. Beginning December of 2007, VISN 12 began a thorough onsite review of patient services at the Oscar G. Johnson VA Medical Center. Since that time, improvements and assistance have continued as evidenced by the following groups:

    a. VISN 12: March 2009, June/July 2009, September 2009

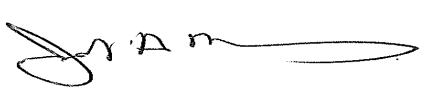
    b. VA/VHA: July 2008 (SOARS), September 2008 (LTCI)

    c. Joint Commission: April 2008 (mock review 2009 standards), March 2009 (triennial), June 2009

    d. Office of Inspector General: July 2009 (CAP)

2. I have reviewed and concur with the recommendations of the Office of Inspector General. The Oscar G. Johnson VA Medical Center is proceeding with the completion of the following attached action plan.

3. The professionalism and consultative manner demonstrated by your team during this review process was appreciated by all.



JEFFREY A. MURAWSKY, M.D.

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 7, 2009

From: Director, Oscar G. Johnson VA Medical Center (585/00)

Subject: **Healthcare Inspection – Alleged Management Decisions Impacting Patient Care and Work Environment, Oscar G. Johnson VA Medical Center, Iron Mountain, Michigan**

To: Director, VA Great Lakes Health Care Network (10N12)

I have reviewed the draft report of the Inspector General's Healthcare Inspection regarding Alleged Management Decisions Impacting Patient Care and Work Environment at the Oscar G. Johnson VAMC. My responses are enclosed.

(original signed by:)

MICHAEL J. MURPHY, FACHE

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

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director takes immediate steps to reduce the scanning backlog and establish a process to assure timely entry of significant information in patients' electronic medical records.

Concur **Target Completion Date: February 1, 2010**

The scanning backlog was decreased from 160 inches at time of the survey (August 18, 2009) to 8 inches as of November 20, 2009. This was accomplished by additional training of staff, including night shift staff during quiet period of their assigned night duties. Health techs have been added to the ED staff and will perform clerical and scanning duties.

The following process has been established to insure timely entry information in the electronic medical records: The Health Information Medical Section (HIMS) Chief receives daily reports from the scanning staff as to the number of pages scanned. The numbers are reported to the Chief of Patient Administration Service (PAS) and monthly reports submitted to the Administrative Executive Board by the Chief of PAS.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires a review of RN staffing to ensure proper coverage of the ED at all times as well as staffing to support NOD duties.

Concur **Completed**

Medical Center Leadership (Director) reviewed the RN staffing in the Emergency Department (ED) along with the Associate Director for Nursing and Patient Care Service. The total number of ED visits from November 24, 2008, to November 25, 2009, totaled 3,968. Of this total, 2,919 were on the day tour, 850 on the evening tour, and 199 on the midnight tour. The average number of patients on the evening shift was 1.46 and on midnights 0.53. Data was also collected to illustrate average

numbers based on day of the week, weekday versus weekend, and average per month. Leadership is not aware of any situation where a critical need was not met due to the absence of the RN in the ED when functioning as the NOD. Staffing models at similar facilities have been reviewed along with Directive 2009-055, titled Staffing. Decisions on staffing levels are based on the recommendations in the Directive related to analysis, tracking, and trending of patient outcome and performance indicators. We concluded that our current staffing model allows us to provide safe high quality care to patients in the most efficient manner possible.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director communicates, orally and in writing, organizational changes to all employees and that administrative supervisory lines are clearly written and effected in official personnel actions.

Concur **Target Completion Date: January 15, 2010**

Medical Center leadership routinely uses various modes to communicate with OGJVAMC employees; for example, quarterly Town Hall meetings, monthly Director's Staff Meetings, weekly all-employee bulletin announcements, ongoing all-employee emails, postings on the OGJVAMC facility homepage, and Medical Center committee minutes. All these communication tools are used to communicate organizational changes and administrative supervisory lines to employees. Management will increase the scrutiny and oversight of the use of these modes of communication to ensure that critical information is disseminated widely throughout the organization. Management also offers two opportunities, manual (anonymous) and electronic, to submit employee suggestions or comments related to a wide variety of issues affecting Medical Center operations. Lastly, the Medical Center Director is about to launch a Director's Blog which will specifically target communication of ongoing issues related to Medical Center operations while providing employees an opportunity to provide specific feedback to management related to these issues. Potential topics include performance, new initiatives, hot topics, customer service, and VA community events. We anticipate the blog will be fully operational by January 15, 2010.

In response to some concerns related to communication identified via the All Employee Survey (AES) earlier this year, the Senior Management Team invited a National Center for Organizational Development (NCOD) team to perform an Organizational Assessment of the Medical Center. The assessment occurred during the last week of September. Part of the action plan resulting from the NCOD assessment is a very detailed all-employee

briefing provided by the Medical Center Director that addresses many areas of concern identified by both the AES and NCOD Organizational Assessment. The briefings began on December 1, 2009; subsequent sessions were held on December 7, 10, 14, and 15. The final session is scheduled for December 16, 2009. Part of the briefing is a reminder that any employee can contact or forward to a member of the leadership team at any level, or to a member of the Performance Improvement staff, issues or concerns they might have. These concerns may be done anonymously. Suggestions, concerns, and questions are also able to be posted to the "Suggestion Box" on the homepage for a member of the Executive Leadership Team to answer within 1 week for those items that require a response. A suggestion box is also available at the elevator of the main entrance for patient, family, and staff use. In the spring of 2009, the Medical Center Director started a rotation of attendance to service level staffing meetings to share communications with staff on a personal level.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Verena Briley-Hudson, MN, RN Director, Chicago Office of Healthcare Inspections (708) 202-2672
Acknowledgments	Lisa Barnes, MSW Judy Brown Paula Chapman, CTRS Roberta Thompson, MSW

Appendix D

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Great Lakes Health Care Network (10N12)
Director, Oscar G. Johnson VA Medical Center (585/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Russell D. Feingold, Herb Kohl, Carl Levin, Debbie Stabenow
U.S. House of Representatives: Steve Kagen, David Obey, Bart Stupak

This report is available at http://www.va.gov/oig/publications/reports-list.asp.