Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Mismanagement of Resources and Quality of Care Issues
Oscar G. Johnson VA Medical Center
Iron Mountain, Michigan

Report No. 12-03146-12

October 18, 2012

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection at the request of Congressman Bill Johnson, Chairman, Subcommittee on Oversight and Investigations, House Veterans' Affairs Committee. The purpose of the inspection was to assess the merits of allegations regarding the mismanagement of government resources and complaints about the quality of care at the Oscar G. Johnson VA Medical Center in Iron Mountain, Michigan. We reviewed the following allegations:

- Registered nurse administrators are being paid registered nurse salaries for performing non-registered nurse duties and assigning themselves overtime while working 1 hour of clinical work per week or short work days.

- There is no peer review for nurses and specialty physicians. Only primary care physicians have to go through peer review.

- Because of a lack of nurse training, critical care trained physicians are not attending to patients, and the administration is spending thousands of dollars to transfer critical care patients out of the hospital.

- Half of the primary care physicians were pushed out of Iron Mountain, and this is affecting patient care in several ways.

    - A 50 percent increase in admissions has increased morbidity and mortality rates.
    - Understaffed primary care physicians are taking care of pre-operative, urgent care, and surgical clearance patients.
    - The emergency department has had a 40 percent increase in workload.

- No intensive care unit physicians or nurses are on the Intensive Care Unit Management Committee or participate in the committee meetings.

- Incompetent nurses extubated three patients in the intensive care unit.

- Intensive care unit nurses do not have appropriate experience or training.

- Administration is recklessly providing opportunities for nurses for doing pet (favored) projects but is not training intensive care unit nurses with intensive care unit competency skills.

We did not substantiate any of the allegations, and we made no recommendations.

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

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

SUBJECT: Healthcare Inspection – Alleged Mismanagement of Resources and Quality of Care Issues, Oscar G. Johnson VAMC, Iron Mountain, Michigan

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the request of Congressman Bill Johnson, Chairman, Subcommittee on Oversight and Investigations House Veterans' Affairs Committee. The purpose of the inspection was to assess the merits of allegations regarding the mismanagement of government resources and complaints about quality of care issues at the Oscar G. Johnson VA Medical Center (the medical center) in Iron Mountain, MI.

Background

The medical center provides general medical and surgical services to veterans in 15 Michigan and 10 Wisconsin counties. The medical center operates 13 medical/surgical, 4 intensive care unit (ICU), and 40 Community Living Center beds. Outpatient care is provided at six community-based outpatient clinics (CBOC) and one rural outreach clinic. The medical center is rated by Veterans Health Administration (VHA) as a Complexity Level 3 medical center[1] with a Level 4 (the least complex designation) intensive care unit[2], and is under the jurisdiction of Veterans Integrated Service Network (VISN) 12.

Allegations

The complainants had multiple complaints regarding mismanagement of government resources and problems with quality of care at the medical center. Specifically, the complainants alleged that:

[1] 2010 VHA Facility Quality and Safety Report, October 2010.
[2] VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures,* May 6, 2010.

- Registered nurse (RN) administrators are being paid RN salaries for performing non-RN duties and assigning themselves overtime while working 1 hour of clinical work per week or short work days.

- There is no peer review for nurses and specialty physicians. Only primary care physicians have to go through peer review.

- Because of a lack of nurse training, critical care trained physicians are not attending to patients, and the administration is spending thousands of dollars to transfer critical care patients out of the hospital.

- Half of the primary care physicians were pushed out of Iron Mountain, and this is affecting patient care in several ways.

    - A 50 percent increase in admissions has increased morbidity and mortality rates.

    - Understaffed primary care physicians are taking care of pre-operative, urgent care, and surgical clearance patients.

    - The emergency department (ED) has had a 40 percent increase in workload.

- No ICU physicians or nurses are on the ICU Management Committee or participate in the committee meetings.

- Incompetent nurses extubated three patients in the ICU.

- ICU nurses do not have appropriate experience or training.

- Administration is recklessly providing opportunities for nurses for doing pet (favored) projects but is not training ICU nurses with ICU competency skills.

Scope and Methodology

We reviewed VHA and local policies, procedures, and other relevant documents pertaining to the allegations including, RN and RN administrators' overtime patterns and nurse and physician peer review documents. In addition, we reviewed objective quality of care measures such as Inpatient Evaluation Center (IPEC) and Veteran Affairs Surgical Quality Improvement Program (VASQIP) data. We reviewed the training records for ICU nurses, physicians' staffing patterns and panel sizes, the electronic health and transfer records of ICU patients, ICU Management Committee meeting minutes, and relevant records related to the ICU nurses participating in non-clinical professional activities. Medical Center workload, the number of hospital admissions, and ED visits were examined. We also interviewed senior managers at the medical center.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Issue 1: Mismanagement of Government Resources

Nurse Administrators' Compensated Salary Rate

We did not substantiate the allegation that nurse administrators are compensated at a RN salary rate for performing non-RN duties. We reviewed the functional statements (job descriptions) for nurse administrators, the medical center's overtime memorandum[3] and the Master Nursing and Patient Care Staffing Plan[4]. We found that nurse administrators are dispatched to assist and support personnel in patient care areas during uncharacteristic increases in patient volume, such as increases in ED visits. The functional statements of the nurse administrators and the Master Nursing and Patient Care Staffing Plan require nurse administrators to provide clinical and supportive measures to ensure the delivery of safe, quality patient care. During our interview with the Associate Chief Nurse, it was confirmed that all overtime for nurse administrators had been approved and was necessary to ensure the delivery of quality patient care.

Nurse Administrators' Overtime Practice

We did not substantiate the allegation that nurse administrators are working 1 hour or fewer clinical hours per week and assigning themselves overtime. The medical center's policy[5] states that all overtime must be approved by a supervisor, is only permitted during times of an emergency, and/or to ensure that the medical center operates efficiently. Additionally, we reviewed the overtime records of RNs who do not routinely provide direct patient care and/or engage in clinical work. From 2009 through 2012, we found nine non-clinical RNs had worked overtime hours. All overtime assignments were approved by the RNs' supervisors and were authorized during times of a Joint Commission review, implementation of a new VHA clinical documentation and support system, and participation in veterans' outreach programs (providing physicals to returning Operation Enduring Freedom/Operation Iraqi Freedom veterans and conducting influenza immunization campaigns).

Patient Transfers

We did not substantiate the allegation that administration is spending tens of thousands of dollars to transfer critical care patients to other facilities and two critical care trained

[3] Iron Mountain Memorandum Number 05-16, *Overtime*, February 19, 2012.
[4] Iron Mountain *Nursing and Patient Care Service (N&PCS), Master Staffing Plan*, June 2011.
[5] Iron Mountain Memorandum Number 05-16.

specialists are not attending to critical patients because the ICU nurses are untrained. The medical center has two specialists with critical care training. While neither specialist performs as an attending in the ICU, it is because they are assigned to other duties and not because of a lack of nurse training. One specialist is board certified in critical care and serves as the chair of the ICU committee as well as consulting on ICU patients. Hospitalists and intensivists are responsible for ICU patients. The medical center has a level 4 ICU, which offers the least complex range of clinical services in the VHA system[6]. Level 4 ICUs do not have the infrastructure and staff to provide complex critical care, specialty procedures, or consultations. We reviewed the discharge summaries of all 67 patients who were transferred out of the ICU from July 13, 2010 to July 6, 2012. Many of these patients were stabilized in the medical center's ICU prior to transfer. We found that the majority of patients were transferred to other hospitals because they required procedures or specialty care that was not available at the medical center. Typically, attending physicians documented the discussion with a physician or specialist at the receiving hospital.

Issue 2: Quality of Care

No Peer Review Process for Nurses or Non-Primary Care Physicians

We did not substantiate the allegation that the medical center does not have a peer review process in place for nurses and non-primary care physicians. We reviewed peer review documents for nurses, PCPs, and specialty physicians for the past 3 years. We found that 45 nurse and 184 physician peer reviews were completed during that period. The physician peer reviews included both primary care and specialty physicians. Additionally, the Associate Medical Center Director, Chief of Staff, senior physicians, and service chiefs all confirmed that the peer review process included nurses and all physicians.

A Decrease in Primary Care Physicians has Affected Patient Care

We did not substantiate the allegation that a loss of half of the PCPs affected patient care. We found that seven PCPs separated from the medical center over the past 2 years; however, the total number of PCPs on board was fairly consistent, ranging from 14 to 17 providers. The medical center was able to hire new physicians to offset their losses.

To assess potential impact of reduced staffing on access to care, we examined the panel sizes of each PCP during the past 3 years. Overall, we found no significant problems with these numbers, although we did find periods where panel sizes exceeded the ideal maximum. However, these events were associated with PCP turnovers and typically lasted only a few months. We also found that primary care clinic wait times have decreased over the past 3 years, with more patients being seen within 14 days.

[6] VHA Directive 2010-018.

Increased Patient Morbidity and Mortality Rates

We did not substantiate the allegation that a loss of PCPs in conjunction with an increase in hospital admissions and ED visits has affected patient morbidity and mortality rates. We reviewed the medical center's 2010–2012 IPEC data and found no significant problems or trends. IPEC data specifically evaluates the at-risk adjusted mortality and morbidity rates for Veteran Affairs Medical Centers. We also reviewed the 2010–2012 VASQIP data, which examines surgical morbidity and mortality rates, and found no significant increases in morbidity or mortality.

In addition, we reviewed medical center admissions and found that admissions have trended downward over the past 3 years. We also reviewed the number of ED visits and found an increase of approximately 5 percent per year over the past 3 years. The Chief of the ED told us that this increase has not impacted patient access or outcomes.

Primary Care Physicians' Duties

We did not substantiate that primary care clinics are understaffed. We found that PCPs are not regularly assigned to staff the urgent care service. Most surgery patients are seen on an outpatient basis by surgeons, and the few that require hospitalization prior to surgery are taken care of by hospitalists and surgeons, not primary care physicians. Although primary care physicians are consulted to assist with the medical clearance of pre-operative patients, this work is typically done on an outpatient basis as part of their primary care duties. Providing this service has not resulted in any complaints from the primary care physicians according to the Associate Chief of Staff for Primary Care.

ICU Physicians' and Nurses' Committee Membership

We did not substantiate the allegation that ICU physicians and nurses are not a part of the ICU Management Committee. According to medical center policy,[7] the ICU committee meets 10 times per year and the ICU nurse manager, ICU nurses, hospitalists, and intensivists are all members of the committee. We reviewed committee meeting attendance records for the past 2 years. We found that ICU nurses attended seven meetings; and the ICU nurse manager and physician that chairs the committee attended all of the meetings.

ICU Nurses' Experience and Training

We did not substantiate the allegation that ICU nurses do not have previous ICU experience and training or that ICU nurses unintentionally extubated three patients. We reviewed the training records and skills competencies for all ICU nurses. We found that nurses received training specific to the ICU environment and the care of ICU patients. The following lists the training and competencies each nurse demonstrated.

[7] Iron Mountain Memorandum Number 11-3, *Intensive Care Unit*, May 16, 2011.

- Management of ventilators
- ICU monitoring equipment
- Care of patients who undergo conscious sedation
- Use of defibrillators
- Responding to life threatening emergencies
- ICU treatment protocols

We also reviewed the electronic health records of all the patients who were intubated in the ICU from July 2010 through June 2012. Of the 12 records reviewed, we did not find documentation that a nurse extubated, participated in, or caused the unintentional extubation of any ICU patients. However, we did find documentation of four unplanned extubations and ICU committee meeting minutes that showed a 75 percent unplanned extubation rate in 2012. Meanwhile, the medical center has implemented a corrective action plan that includes altering the sedation protocol and updating the devices used to secure the endotracheal tube for ventilated patients.

ICU Nurses Involvement in Non-Patient Related Activities

We did not substantiate the allegation that ICU management encourages ICU nurses to engage in activities that are not directly related to ICU patient care. We reviewed the committee membership and project involvement of the ICU nurses. We found the ICU nurses participate in projects directly related to improving patient care, on-going professional education, and other mandatory medical center committees. For example, ICU nurses participate in medical center-wide infection control, palliative care, and anticoagulation protocol projects.

Conclusions

We did not substantiate the allegations of mismanagement of government resources or quality of care issues at the medical center. We made no recommendations.

Comments

The VISN and Facility Directors concurred with our findings. (See Appendixes A and B, pages 7 and 8, for the full text of the Directors' comments.)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN 12 Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 18, 2012

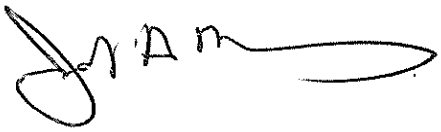
From: Director, VA Great Lakes Health Care System (10N12)

Subject: Healthcare Inspection – Alleged Mismanagement of Resources and Quality of Care Issues, Oscar G. Johnson VAMC, Iron Mountain, MI

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

1. I have reviewed the OIG findings and conclusions regarding the allegations outlined in the draft copy of the OIG Healthcare Inspection Report pertaining to the Oscar G. Johnson VA Medical Center and concur with the OIG that the noted allegations are unsubstantiated.

2. If you have any questions or need additional information, please contact Chris Iacovetti at (708) 492-3918.



Jeffrey A. Murawsky, M.D.

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 18, 2012

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

Subject: Healthcare Inspection – Alleged Mismanagement of Resources and Quality of Care Issues, Oscar G. Johnson VAMC, Iron Mountain, MI

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

1. I have reviewed the OIG findings and conclusions regarding the allegations outlined in the draft copy of the OIG Healthcare Inspection Report pertaining to the Oscar G. Johnson VA Medical Center and concur with the OIG that the noted allegations are unsubstantiated.

2. If you have any questions or need additional information, please contact Mary Gagala, Quality Manager, at (906) 774-3300, extension 32035.

(original signed by:)
James W. Rice

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Robert Yang, MD, Project Leader Debra Boyd-Seale, PhD, RN, Team Leader Sheila Cooley, MSN, RN Wachita Haywood, RN La Nora Hernandez, RN Judy Brown, Program Support Assistant

Appendix D

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