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Veterans Integrated Service Network 23
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September 14, 2015

The Honorable Timothy J. Walz
527½ South Front Street
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Dear Congressman Walz:

Thank you for your letter of September 2, 2015 requesting a status report of our oversight of improvement actions related to VA OIG Hotline Case #2014-00459-HL-0044, which described insufficient staffing and alleged managerial issues at the St. Cloud VA Health Care System. The allegations were thoroughly reviewed, appropriate action plans were implemented, and the OIG closed the inquiry on February 9, 2014.

The leadership team at the St. Cloud VA welcomed the opportunity for improvement provided by the OIG Hotline inquiry and subsequent review. They continue to take the review findings seriously—including those allegations which were substantiated and those which were not—and have diligently worked to incorporate the findings into their ongoing, continuous efforts to improve the organization and the care provided to Veterans.

VISN 23 continues to monitor the findings through our ongoing quality management programs, annual workplace evaluations, executive leadership council, a variety of other management venues, as well as internal and external reviews. Additionally, we maintain a rigorous program of continuous monitoring of performance metrics and data for St. Cloud and the other seven health care systems in the VA Midwest Health Care Network. Through the combination of effective management controls, meaningful support structures and capable, dependable staff we are confident that St. Cloud VA continues to deliver the high quality of care Veterans are accustomed to receiving.

We have highlighted the six specific questions in your letter and included our response to each:

1. Physician and mid-level provider resignation. *The report substantiated the allegation that "many physicians and mid-level providers have recently (2013) resigned*. Can you assure me and my constituents who seek care at the St. Cloud facility that they have recruited and retained a sufficient number of physicians and mid-level provers since you concluded your report? Please provide me any relevant data to back up your assessment.

Yes, Veterans can be assured of receiving high-quality health care at the St. Cloud VA, which currently has seen an improvement in the number of primary care providers. It is important to note that some degree of provider turnover is normal in health care organizations. While there has been improvement, the ongoing need for additional providers is by no means satisfied and recruiting continues to be a priority. Recruiting and retaining physicians to a Level 3 facility which is non-affiliated and located in rural Minnesota is very challenging. Additionally, finding qualified physicians, who can provide quality care, are accountable and reliable, and are engaged in the mission of the organization despite the geographic challenges adds another level of complexity to the recruitment and retention process.

In response to the provider departures in the summer of 2013:

- St. Cloud initiated a recruitment workgroup to enhance outreach and other recruitment strategies with the goal of increasing the number of permanent medical staff. In FY 14 these efforts resulted in the hiring of eight physicians and 14 mid-level providers. In addition to those gains, seven locum tenens providers and one contracted provider were hired as temporary support during the hiring process of the permanent medical staff. This effort continues. In FY 15 St. Cloud has added eight physicians and six mid-level providers across the organization, and is in the process of hiring more.

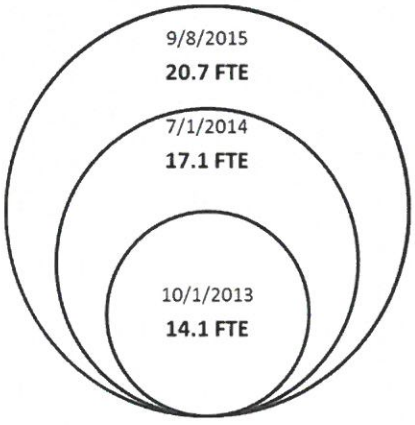
- In consultation with provider staff, the orientation and training plan for new providers was revised, to include the assignment of a mentor.

- Graduated clinic schedules were implemented for new providers.

- Established providers made a commitment to maintain higher panel sizes to support new providers.

The sum of these efforts is an increase in the number of full time provider equivalents managing patient panels (see Figure 1).

Figure 1: *The growth in the number of full time provider equivalents (FTE) engaged in panel management in primary care settings has positively impacted Veteran care and reduced panel sizes.*



In FY15, St. Cloud has lost the equivalent of three full-time primary care physicians and recruited one full-time primary care physician. In addition to continual recruiting for physicians, they continue to recruit mid-level providers to help balance the workload, and have recruited and are on-boarding seven additional mid-level primary care providers.

Their recruiting measures are making progress. It is a continuing challenge to hire and retain permanent primary care physicians. VHA workforce challenges mirror those of the health care industry as a whole. We are in a fiercely competitive health care recruitment market and face similar challenges as our private sector counterparts. These challenges include: the growing national shortage and availability of experienced, quality candidates who possess the competencies required for the position; the salaries typically paid by private industry for similar positions; employment trends and labor-market factors that may affect the ability to recruit candidates; and other factors such as rural/highly rural locations that may be considered less desirable.

VA has increased salaries for physicians and dentists to close the pay gap with the private sector and to make VA an employer of choice. St. Cloud has adjusted salaries to support enhanced recruitment and retention efforts. VA is expanding the loan repayment program, as included in the Choice Act, which increased the maximum reimbursement ceiling for the Education Debt Reduction Program from $60,000 to $120,000. This has been a very positive factor in recruitment successes at St. Cloud and our other facilities.

2. Management issues. The report substantiated the allegation of *"disrespectful manner by senior management."* It said *"we received comments from more than one disciple and PACT teams on fear of reprisal and not wanting to get on the bad side of the Medical Center Director and Chief of Staff."* Can you assure me and my constituents who receive care at the St. Cloud facility that the workplace conditions you identified have been corrected at the facility? What documentation can you share with me and the public to support your conclusions? If conditions have not improved, what additional steps are you taking to address the situation?

The report also stated that there were variations in responses received by the PACT team members, including PACT teams that were very positive and ones that were extremely negative. Substantial effort has been made over the past two years to correct these negative perceptions while reinforcing the positive perceptions. To improve employee perceptions of organizational climate, St. Cloud has implemented the following actions:

- Senior leaders meet regularly with primary care providers to increase visibility and communication.
- National Center for Organization Development (NCOD) was contacted to assist with the development of All Employee Survey action plans. St. Cloud continues to consult with NCOD.

- Senior Leader rounding and participation in Service Line meetings.
- Supervisory training programs on communication skills, addressing bullying the workplace and promoting employee development.
- Trial of Supervisor/Leader rounding in a number of Service Lines.
- Implementation of Town Hall or open employee forums between employees and Service Line leaders.
- Employee training programs on career development.
- Use of funding programs to support employees.
- Utilization of CREW (Civility, Respect, and Engagement in Workplace) program with five new work teams.
- Incorporating ICARE and CREW principles during all employee events.
- Involvement of front line employees in the development of Service Line All Employee Survey Action plans.

These employee engagement priorities have yielded positive results.

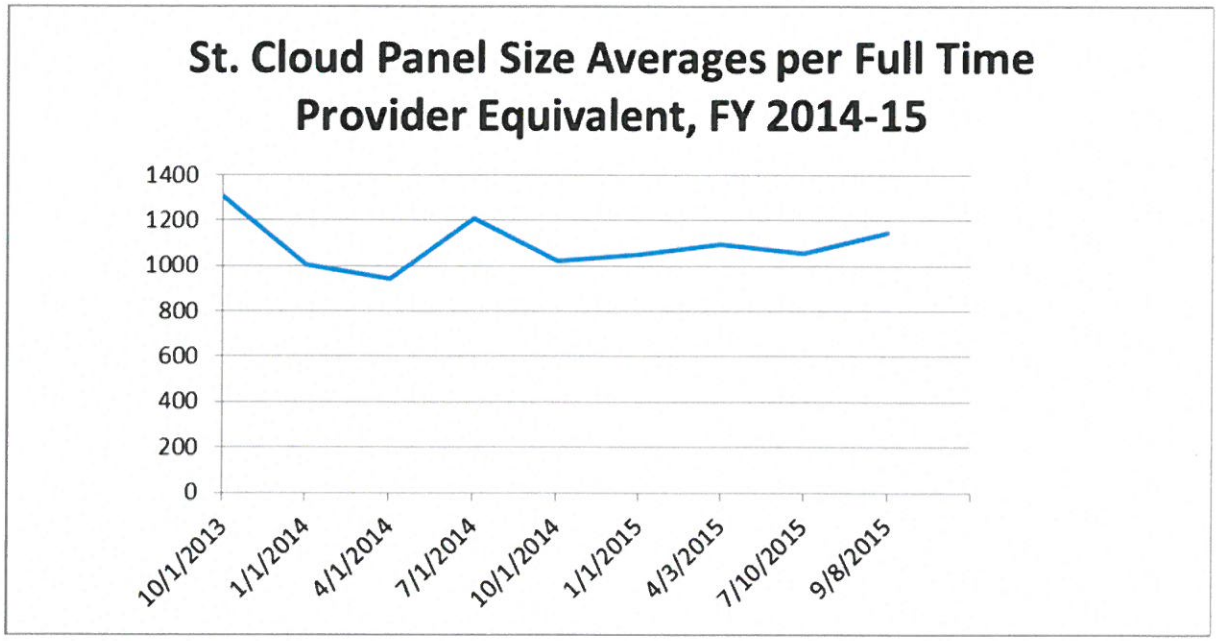
- The All Employee Survey (AES) over the past two cycles (FY2013, FY2014) have shown a positive shift in their perception of improvement in patient safety and overall organizational climate. In addition, the medical center has shown a positive increase in the area of Psychological Safety from the FY2013 AES report to the FY2014 AES report. The change indicates an increase in the providers' belief that they can bring up problems and issues to their workgroup including new ideas without negative repercussions. **Attachment 1** contains a comprehensive summary of 2014 AES findings for the physician workgroup.

- 2013 VA SAIL Data (comparison data against 152 VA medical centers, derived from All Employee Survey (AES)) ranked St. Cloud as 113/152 in the "Best Place to Work" category; 2014 SAIL data ranked St. Cloud as 85/152.

- St. Cloud just completed the AES for 2015. Results are due in 2-3 months. What we know is that a record 69% of St. Cloud VA employees completed the AES—more than in any other previous year and more than any other facility in VISN 23. The employees in St. Cloud are engaged in their workplace, and we are confident the leadership will listen to their employees and use the information to improve the organization.

3. Panel sizes. *The report substantiated the allegation that panel sizes grew to 150% of recommended as of July 1, 2013.* Can you please provide me with what steps have been taken to bring the panel size down to recommended levels? Please provide me the most current data concerning panel sizes.

Panel size is the number of unique patients for whom a care team is responsible. In VHA, the patient panels of physicians who depart are redistributed to the remaining providers, and this procedure contributed to the increased panel sizes experienced during the summer of 2013. The primary means of reducing panel sizes is the recruitment and retention of providers, and St. Cloud, as discussed previously, has improved the number of providers managing primary care panels. In VHA, the baseline expected panel is 1,200 patients for a full-time physician provider. After adjustment for various factors, expected panels for VHA primary care providers largely fall in the range of 1,000 to 1,400, per VHA Handbook 1101.02. From the time of the report, panel sizes are significantly improved.



On October 1, 2013, average primary care panel size was 1308 patients per full time provider equivalent. On October 1, 2014, the average panel was 1026 patients per full time provider equivalent. As of September 8, 2015, the average panel is 1147 patients per full time provider equivalent.

Regardless of assigned panel size, primary care providers are assigned a maximum of twelve 30-minute appointment slots per day. Each physician or mid-level provider is supported by dedicated team—including an RN, LPN and medical support assistant, and dedicated access to a clinical pharmacist. This team directly supports the provider in managing the health care needs of the assigned patient panel. Such a team structure is found across VHA.

4. Canceled appointments. The report substantiated the allegation that a number of appointments had been cancelled due to insufficient staffing. It found that *"canceled by clinic for St. Cloud 19.5% of all appointments compared to the VISN23 average of 12.08%."* What has been done since the report to being the rate down to acceptable levels?

While subject to a number of variables, the primary determinant of cancellation rates is the presence or absence of a provider in the clinic. St. Cloud's recruiting efforts have favorably impacted the cancellation rates in primary care settings. Rates of appointments "cancelled by clinic" in primary care settings at St. Cloud have declined from 12.63% in FY 14 to 10.97% to date in FY 15 (see Table 1).

Table 1: *Primary Care Clinic Cancellation Rates, St. Cloud VA Health Care System*

FY 13 Total Average Cancelled by Clinic	*FY 14 Total Average Cancelled by Clinic*	*FY 15 Total Average Cancelled by Clinic*
11%	**12.63%**	**10.97%**

As in every VHA facility without an Emergency Room, St. Cloud has procedures in place to ensure that patients without a scheduled appointment and with emergent or urgent needs are seen the day they present. Additionally, the Urgent Care Center is available for walk-in service 8 a.m. to 6 p.m. seven days week, 365 days a year, and patients needing care outside of these hours can present at Bldg. 111 for assessment and appropriate treatment.

5. Death rates. *The report substantiated the allegation that staff had to review many lab results, outside records, medication requests, as it was afraid to miss something that could lead to a Veteran's death. The report stated "death rates were within normal variance for all but two providers, both located at two separate CBOCs. One provider is under active surveillance, the second provider will be evaluated by the Primary Care Service Line Director."* Can you please provide me with an update on the status of your overview of both providers and the care they are providing Veterans? Has there been any significant issues with either of these providers since your report?

On-going monitoring of the outcomes and quality of care of all medical staff members is the responsibility of the Professional Standards Board, the Peer Review Committee, and the Medical Executive Committee of the Medical Staff. The two providers in question were reviewed by these bodies. Following those reviews, including intense additional monitoring of one provider, no significant quality of care issues were identified for either provider.

6. Progress report. The report said that VISN leadership will monitor the facility's improvement actions until findings are addressed. Can you confirm that all findings have been fully addressed? If not, what additional steps are being taken to correct the situation?

The allegations were thoroughly reviewed, appropriate corrective action plans were implemented, and the OIG closed the inquiry on February 9, 2014. It is important to note that action plans are ongoing and embedded into numerous recurring reviews and processes. It is also important to understand that many of the findings involve

dynamic and ongoing processes, and peaks and valleys can be expected. Health care provider and staff turnover, for example, is a constant issue, and recruiting and retention remains an ongoing priority.

VISN 23 continues to conduct oversight of the improvement actions noted in the report. We accomplish this through site visits, meetings, continuous monitoring of data, discussion between leaders and in quality management forums, and monitoring of external review results. Specific to panel sizes and clinic cancellation rates, the VISN 23 Primary Care Service Line Director routinely monitors these and other key metrics for all facilities.

The leadership team at the St. Cloud VA continues to take the review findings seriously and has diligently worked to incorporate the findings into their ongoing efforts to improve the organization and the care provided to Veterans. Additionally, aggressive efforts are underway to improve workplace perceptions, which are measured on the annual All Employee Survey.

St. Cloud VA consistently delivers safe, quality care, as evidenced by numerous, ongoing measurements of quality, including internal and external reviews by the OIG and various accreditation agencies (see Table 2).

Table 2: *Significant recent external reviews of the St. Cloud VA Health Care System*

Reviewer Name	Type of Review	Date of Review	Results of Review
The Joint Commission	Accreditation Visit	October, 2013	3-Year Accreditation Achieved
Office of Inspection General (OIG)	Combined Assessment Program Review	November, 2014	No findings noted in Quality Management, Facility received only one finding (MRI documentation).
Office of Inspector General (OIG)	Community Based Outpatient Clinic Readiness Assessment	November, 2014	One finding related to timing of fire drills which had been identified and rectified by the facility prior to visit.
Commission on Accreditation of Rehabilitation Facilities (CARF)	Homeless Program Accreditation Visit	March, 2015	3-Year Accreditation Achieved
Commission on Accreditation of Rehabilitation Facilities (CARF)	Mental Health Rehabilitation and Recovery Services Accreditation Visit	March, 2015	3-Year Accreditation Achieved

Long Term Care Institute (LTCI) Survey	Community Living Center Review	June, 2015	7 findings, a decrease of 4 findings from previous visit. No finding had a rating of "immediate jeopardy".
The Joint Commission Special Focus Survey	Special Focus Survey (contracted by VA in response to Phoenix access issue)	June, 2015	Zero findings.

Significantly, Veterans continue to seek VA healthcare in ever increasing numbers. St. Cloud is experiencing an approximate 3% growth in unique patients served in FY 15, and expects to serve more Veterans this year than ever before. Such growth exerts continuous pressure on staff and the services needed by today's Veterans. Nevertheless, currently 97.5% of all St. Cloud appointments are completed within 30 days of the clinically indicated date, and quality of care remains high. In addition, Veterans are referred to the Veterans Choice Program whenever needed services are not offered or cannot be provided in a timely manner.

The St. Cloud VA Health Care System senior leadership team seriously considered the findings of the VA OIG Hotline Case, implemented appropriate on-going corrective actions, and has remained actively engaged and committed in their efforts to support the clinical staff. Despite significant recruitment challenges, provider staffing levels have increased, and employee workplace perceptions have improved. In addition, on-going reviews by VISN and external reviewers have consistently validated the quality of care provided to Veterans served by the St. Cloud VA Health Care System.

Respectfully,

Steven C. Julius MD

STEVEN C. JULIUS, M.D.
Acting Network Director

Attachment