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OFFICE OF INSPECTOR GENERAL

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VETERANS HEALTH ADMINISTRATION

Review of Staffing and Access Concerns at the Mann-Grandstaff VA Medical Center

Spokane, Washington

HEALTHCARE INSPECTION | REPORT #19-09017-64 | JANUARY 8, 2020

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Review of Staffing and Access Concerns at the Mann-Grandstaff VA Medical Center Spokane, Washington

On July 26, 2019, the VA Office of Inspector General (OIG) was notified of staffing and access concerns at the Mann-Grandstaff VA Medical Center in Spokane, Washington. Specifically, the OIG was told that

1. Seven providers left (employment) in the previous month;
2. The intensive care unit (ICU) was closing due to inadequate staffing;
3. Only one operating room was functional; and
4. The Acting Chief of Radiology was a dentist.[1]

The OIG Rapid Response Team conducted an inspection July 29–August 1, 2019, to assess the merit of the concerns.[2]

How the OIG Conducted the Review

The OIG interviewed facility leaders, managers, and staff. The OIG reviewed relevant Veterans Health Administration (VHA) directives and facility policies, meeting minutes, quality management documents, and human resource management tracking data. The OIG also reviewed the facility's overall ranking related to inSight Model measures.[3] The OIG conducted the review in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[1] The OIG was initially told that the former Chief of Radiology left employment without an adequate replacement, suggesting that the person left without notice. However, the team later found that the former Chief stepped down from the position in June 2019, which was a planned and voluntary decision, and continued to work in the Radiology Service.

[2] As OIG rapid response work is generally limited in scope, issues identified during the course of the review that are beyond the scope are dispositioned in accordance with established OIG practices.

[3] The OIG inSight Model for Medical Center Quality, Efficiency, and Productivity was developed to assist with the identification and assessment of health care quality, access, and value within VHA. This model uses VA reporting systems such as the VA Inpatient Evaluation Center for inpatient quality of care, the Emergency Medicine Management Tool for Emergency Department processes, performance measure reports for inpatient and outpatient quality of care measures, as well as others. This information is located on an internal OIG website not publicly accessible.

Background

The Mann-Grandstaff VA Medical Center (facility) is part of Veterans Integrated Service Network (VISN) 20. From October 1, 2017, through September 30, 2018, the facility provided services for approximately 34,000 veterans residing in eastern Washington, northern Montana, and Idaho. The facility's acute inpatient service consisted of 12 mental health beds, 4 ICU beds, 10 acute care unit beds, and 10 general medical-surgical beds.[4] The facility also operated a 34-bed Community Living Center. The facility coordinates referrals to the VA Puget Sound Health Care System and VA Medical Center Portland for tertiary care, as well as utilizes community health care resources. VA classifies the facility as Level 3, with a standard operative complexity level.[5]

Summary of OIG Findings

Although the OIG confirmed aspects of the concerns listed above, the team did not find that those conditions were inherently problematic. Facility leaders were generally aware of the concerns and had made reasonable management decisions to address them.

1. Seven providers left (employment) in the previous month.

The OIG team confirmed that seven providers left employment at the facility during June 3–July 21, 2019; however, the OIG did not find that the loss of the seven providers was unexpected or unusual.[6] The seven providers represented multiple disciplines and were from varied departments, and the provider losses were due to a combination of internal transfers, planned retirements, and resignations. Therefore, the OIG determined that the proximate timing of the seven provider losses was coincidental and not part of a planned provider exodus.

The Facility Director told the OIG that the facility had approximately 1,200 employees, which was an increase of more than 300 personnel since 2014. However, despite increased staffing across all departments, turnover among physicians and recruitment of specialists such as

[4] Acute care beds are also known as step-down unit beds and are designated for patients who do not need ICU level of care.

[5] VHA Office of Productivity, Efficiency and Staffing. The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most administratively complex. Level 3 facilities are the least complex. This information is located on an internal VA website not publicly accessible. VHA Directive 1220, *Facility Procedure Complexity Designation Requirements to Perform Invasive Procedures in Any Clinical Setting,* May 13, 2019. VA assigned inpatient medical centers an operative complexity level of standard, intermediate, or complex based on facilities, equipment, workload, and staffing load. The Invasive Procedure Complexity Model ensures that medical facilities' infrastructure matches the complexity of the invasive procedures performed in any clinical setting.

[6] Because employment separations typically occur at the end of a two-week pay period, the OIG expanded the review range beyond "the previous month" to include the pay periods spanning June 3–July 21, 2019.

oncologists and pulmonologists, continued to be a challenge due to competition with private sector opportunities.[7]

The Chief of Staff (COS) confirmed that in recent months, physician losses included three hospitalists, and a neurologist, radiologist, psychiatrist, and primary care physician. However, the COS characterized those losses as due to a variety of reasons and not the result of an exodus of providers. Although the facility had to curtail admissions to its medical-surgical units in summer 2019 as the result of physician turnover, the COS told the OIG that, with four large non-VA hospitals in the local community, providing patients with access to services not available at the facility did not present a problem.[8] The Chief of Urgent Care Center told the OIG that the facility had processes in place for services not available, such as referrals for emergency evaluation and admissions after urgent care clinic business hours. The OIG interviewed additional clinical leaders, none of whom expressed concerns that patients did not have access to needed services.

The provider losses in question were relatively recent at the time of OIG's site visit in late July and not enough time had elapsed to fully evaluate potential effects of those losses. However, the OIG noted that access to some outpatient care, particularly for new primary care patients, started to decline around May 2019.[9] Further, as of August 31, 2019, the percent of primary care new patient appointments completed less than 30 days from the created date declined from more than 80 percent in April to less than 40 percent in August, while the overall VHA average in this measure remained relatively stable (around 80 percent).[10] Though the OIG identified that preliminary data in September was improving from August, it is imperative for the facility to ensure that patients have timely access to care.

2. The ICU was closing due to inadequate staffing.

The OIG confirmed that the facility was in the process of determining whether to close (or repurpose) the existing ICU; however, a final decision had not been made at the time of the inspection. In the context of historically low ICU utilization, provider vacancies, and concerns surrounding nurse and physician abilities to maintain ICU-level competencies, the OIG determined facility leaders' actions to be in the best interests of safe patient care.

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[7] VA Office of Inspector General, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY 2018*, Report No.18-01693-196, June 14, 2018. The OIG reported the most commonly cited challenges to staffing fell into three categories: (1) lack of qualified applicants, (2) non-competitive salary, and (3) high staff turnover.

[8] The facility is continuing to recruit to fill provider vacancies through the resource management board request and approval process.

[9] At about the same time, performance data also reflected a downward trend for the percent of established patient appointments being completed within 30 days of the date a patient requested an appointment.

[10] Primary Care Wait Time is the percent of new patient appointments completed within 30 days from the date the appointment was made.

The COS reported that the ICU consisted of four beds, and over the last three to four years, had an average daily census of 0.1 to 0.2 patients per day. This means there were days when no patients or only one patient was being cared for in the ICU. With low ICU utilization, facility leaders were concerned that nursing staff and physicians might not be able to maintain the full range of competencies and skills needed to provide ICU-level care.

After analyzing ICU volume, mortality data, monthly admissions, tele-ICU utilization, staffing, and internal quality management reviews, in June 2019 the Executive Leadership Board discussed closing the ICU.[11] A multidisciplinary team was formed to analyze the potential impact on patients, staff, and the facility at large of closing the ICU. Reportedly, the team expected to complete the analysis and provide recommendations to facility leaders in early to mid-September 2019.

3. Only one operating room was functional.

Clinical leaders told the OIG that as of July 27, 2019, the facility was temporarily utilizing one of its two operating rooms.[12] The OIG found the decision to curtail operating room utilization was the result of Sterile Processing Services (SPS) staffing shortfalls and other deficiencies identified during a visit from the National Program Office for Sterile Processing (NPOSP) in early July.[13]

The Facility Director told the OIG that because of a non-competitive pay scale, retention among SPS technicians was low. According to the Chief of SPS, SPS lost four staff members since February 2019. As an interim measure, dental procedures were curtailed to include stopping all procedures by 3:00 p.m. each day so that SPS would have time to reprocess that day's reusable medical equipment (RME). Additionally, SPS could only support RME reprocessing for less than 20 operating room procedures daily. SPS continued to experience a steady loss of staff, with a high of six vacancies (of 13 positions) noted as of July 12, 2019. The Chief of SPS reported, and the OIG confirmed, that since October 2018, dental procedures and operating room utilization had increased, but SPS staffing had not increased.

From July 8–11, 2019, at approximately the same time SPS staffing shortfalls peaked, the NPOSP evaluated SPS operations in the areas of decontamination, sterilization, high-level

[11] The tele-ICU is a support service designed to supplement on-site ICU coverage when this service cannot be adequately or practically provided locally. https://www.minneapolis.va.gov/services/Tele-ICU.asp. (The website was accessed on September 11, 2019.)

[12] While reviewing July operating room utilization reports, the OIG found occasional use of the two rooms.

[13] VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016. SPS is responsible for decontamination, high-level disinfection, and/or sterilization of critical and semi-critical reusable medical equipment and instruments. SPS supports the medical facility by ensuring a continuous flow of processed critical and semi-critical instruments to all points of use.

disinfection, and storage of reprocessed RME.[14] Among other concerns, NPOSP found that staffing shortages impacted the ability of SPS to "effectively meet the minimum VHA requirements and adherence" to VHA policies.[15] Although NPOSP did not direct the facility to suspend SPS operations as a result of identified deficiencies, facility leaders determined that, in the context of SPS staffing shortfalls, temporarily reducing the number of operating room procedures and dental services to decrease the volume of items requiring sterile processing was necessary and in the best interest of patient safety. Providers' operating room schedules were rearranged to optimize operating room capacity and efficiency, resulting in only two canceled cases during the first week. This curtailing of services would allow SPS to implement corrective actions and hire additional staff. The OIG team was told that an interdisciplinary team, under the direction of the Associate Director for Patient Care Services, had been meeting weekly to review progress in hiring additional SPS staff and addressing other deficiencies identified by the NPOSP.[16] Although the facility was uncertain when operating room utilization would return to its previous levels, leaders projected that by September 2019, incremental increases in operating room utilization and dental services were possible.

4. The Acting Chief of Radiology

The OIG confirmed that a dentist was the Acting Chief of Radiology; however, the team did not find this to be a concerning leadership decision. The COS told the OIG that the dentist, who was the Chief of Dental Service, was identified as a strong leader capable of providing administrative oversight while facility leaders evaluated certain business aspects of the department and recruited a Chief of Radiology with the necessary background and clinical skills to meet those needs.

Reportedly, the previous Chief of Radiology wanted to work fewer hours and voluntarily stepped down from the leadership role in late June 2019 to fill a staff radiologist position vacated earlier that month. As a result, the Chief of Dental Service was detailed to the position of Acting Chief of Radiology with responsibility for administrative oversight. Clinical oversight continued to be the responsibility of the staff radiologist. The Facility Director told the OIG that the Chief of Dental Service had strong leadership skills and was the right person to guide Radiology staff in overcoming previous internal conflict within the department. Additionally, the Chief of Dental Service had previously served as the Acting Deputy COS on several occasions and was familiar with the responsibilities associated with this type of leadership role.

[14] Decontamination is process of cleaning and disinfecting items before sterilization. Sterilization is a process used to make an item free of microorganisms. High-level disinfection is a process that uses a sterilizing agent for a short time to kill microorganisms. Storage of reprocessed RME maintains sterility after reprocessing until the item is used.

[15] The NPOSP report highlighted additional concerns including competency completion, reprocessing instructions and procedures, equipment tracking, and the quality assurance program.

[16] During a routine July 2019 site visit, the NPOSP team identified several deficiencies in the SPS program, such as lack of staff competencies, expired standard operating procedures, missing policies, and inadequate equipment tracking.

Disposition and Follow-Up

During the course of this review, the OIG team identified additional concerns outside of the original project scope that had the potential to impact patient care, including staffing and hiring issues, Cerner electronic health record system implementation, mental health program performance, and executive leadership dynamics.[17] In accordance with OIG practices, those concerns will be assessed, dispositioned, and followed-up through established OIG processes.

The OIG discussed the concerns outlined in this report, as well as those potentially needing additional review, with the Facility Director. In a separate conversation, the VISN Director acknowledged awareness of the issues discussed in this report.

Conclusion

The OIG team confirmed that seven providers left employment at the facility from early June through mid-July; however, the OIG did not find that the loss of the seven providers was unexpected or unusual. The seven provider losses were due to a combination of internal transfers, planned retirements, and resignations, and did not appear to represent a mass exodus. Recruitment of specialists such as oncologists and pulmonologists continued to be a challenge due to competitive benefits available at other community hospitals. The OIG noted that access to some outpatient care started to decline around May 2019, and while improving in September, ongoing vigilance is needed to ensure patients receive timely access to care.

The OIG team confirmed that due to low ICU utilization and an average daily census of 0.2 patients per day over several years, the facility formed a multidisciplinary team to analyze the potential impact on patients, staff, and the facility at large of closing the ICU.

As of late July 2019, the facility was temporarily utilizing only one of its two operating rooms. The decision to curtail operating room utilization was the result of SPS staffing shortfalls and other deficiencies identified during a visit from the NPOSP. Facility leaders determined that, in the context of SPS staffing shortfalls, a temporary reduction in operating room procedures and dental services to decrease the volume of items requiring sterile processing was in the best interest of patient safety.

The OIG confirmed that a dentist was functioning as the Acting Chief of Radiology. The previous Chief of Radiology voluntarily stepped down from the leadership role in late June 2019 to fill a staff radiologist position. The Chief of Dental Service was detailed to the position of Acting Chief of Radiology based on previous leadership experience and qualifications. The Chief of Dental Service was responsible for administrative operations and clinical oversight continued to be the responsibility of the staff radiologist.

[17] The facility is a pilot site for the VHA Cerner electronic health record integration. Clinical and technical obstacles have been anticipated as part of the large-scale information technology deployment and transition.

Although the OIG confirmed aspects of the reported concerns, the team did not find that those conditions were inherently problematic. Facility leaders were generally aware of the concerns and had made reasonable management decisions to address them. The OIG identified several potential issues outside the scope of this rapid response review. Those issues will be assessed, dispositioned, and followed-up through established OIG processes.

Recommendations 1–2

1.The Mann-Grandstaff VA Medical Center Director takes action to ensure that patients have timely access to care.

2.The Mann-Grandstaff VA Medical Center Director ensures continued implementation of corrective actions in response to deficient areas identified in the National Program Office for Sterile Processing report.

Comments

The VISN and Facility Directors concurred with the recommendations and provided acceptable action plans. (See appendixes A and B.) The OIG will follow up on the planned actions until they are completed.

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

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: Nov 26, 2019

From: Director, Northwest Network (VISN 20)

Subj: Healthcare Inspection—Review of Staffing and Access Concerns at the Mann-Grandstaff VA Medical Center, Spokane, Washington

To: Director, Rapid Response, Office of Healthcare Inspections (54RR00)
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. Thank you for the opportunity to review the report Review of Staffing and Access Concerns at the Mann-Grandstaff VA Medical Center.
2. Attached please find the VISN's concurrence and response to the findings from the review.
3. If you have additional questions or need further information, please contact Terisa Sjue-Loring, Chief Nurse Officer/Quality Management Officer, VISN 20 at (360) 619-5930.

(*Original signed by:*)

John Mendoza
On behalf of Michael J. Murphy
VISN 20 Network Director

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: Nov 22, 2019

From: Medical Center Director, Mann-Grandstaff VA Medical Center (668/00)

Subj: Healthcare Inspection – Review of Staffing and Access Concerns at Mann-Grandstaff VA Medical Center, Spokane, WA

To: Network Director, VISN 20 (496/10N20)

1. Attached you will find Mann-Grandstaff VA Medical Center's response to the Office of Healthcare Inspections Review conducted during the week of July 29, 2019.

2. The staff at MGVAMC is committed to continuously improving processes and care provided to our Veterans. We are implementing a plan to address each recommendation made by the Office of Healthcare Inspections Team.

3. For any questions or concerns, please contact Sam McComas, Chief of Quality, Safety and Value, at (509) 434-7300.

(*Original signed by*:)

Richard Richards
On behalf of Robert J. Fischer, MD
Medical Center Director

Facility Director Response

Recommendation 1

The Mann-Grandstaff VA Medical Center Director takes action to ensure that patients have timely access to care.

Concur.

Target date for completion: February 2020

Director Comments

Mann-Grandstaff Veterans Affairs Medical Center (MGVAMC) implemented the VA Maintaining Systems and Strengthening Integrated Outside Networks Act (MISSION Act) in June 2019. This provides eligibility for Veterans unable to be seen within 20 days for Primary Care and Mental Health and 28 days for specialty care to receive care in the community. MISSION related access metrics are reviewed on a quarterly basis by clinical and executive leadership. MGVAMC is reviewing facility data on a monthly basis until the MISSION Act access standards for new patient wait times is met for at least six consecutive months.

To further support timely access to care, MGVAMC has started implementation of the Improving Capacity, Efficiency and Productivity (ICEP) principles established for VA Medical Centers and processes across the services of Primary Care, Mental Health, Gastroenterology (GI), and Cardiology. The ICEP approach includes standardizing core processes and data accuracy; implementing strong practice solutions and shaping demand; and utilizing innovative methods of care and performing a make/buy decision. Target date for completion for implementation of ICEP principles and processes is February 2020.

According to the PACT Profile reporting tool created by the ICEP initiative, comparing New Patient appointments out of 50 Stop Codes/Divisions/Clinics in the last 30 days, Primary Care met the target of ensuring patients had timely access to care within 20 days, and Specialty Care met the 28-day metric with 38 Stop Codes/Divisions/Clinics.

In addition to traditional clinic services provided at the MGVAMC, the VA also provides telehealth services, walk-in clinics, Saturday clinic options, and provides Care in the Community alternatives for Veterans to increase their options and decrease wait time.

With the addition of Sterile Processing staff, we plan to increase Operating Room utilization in March 2020.

Recommendation 2

The Mann-Grandstaff VA Medical Center Director ensures continued implementation of corrective actions in response to deficient areas identified in the National Program Office for Sterile Processing report.

Concur.

Target date for completion: March 2020

Director Comments

MGVAMC is grateful to the National Program Office for Sterile Processing (NPOSP) for identifying deficiencies in our sterile processing policies, procedures, and program execution. With the addition of six new staff to fill all vacant positions, the Chief of Sterile Processing Service has been able to devote time to revising the training plan to ensure all competencies are brought current, consult with clinics to review and approve required SOPs, and develop a new process to ensure all Reusable Medical Equipment (RME) is reviewed by SPS prior to purchase or order. The Associate Director of Patient Care Services (ADPCS) is providing oversight of the corrective action plans and coordination of preparations prior to resuming normal operations that are dependent on Sterile Processing Services (SPS). To ensure all program improvements are sustained, SPS reports quarterly progress on corrective action plans through the RME Committee to the Quality Council, which is co-chaired by the Medical Center Director and the Chief of Quality, Safety and Value (QSV).

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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