

CAPITOL OFFICE
1034 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-2472

MANKATO OFFICE
527 1/2 SOUTH FRONT STREET
MANKATO, MN 56001
(507) 388-2149

ROCHESTER OFFICE
1202 1/2 7TH STREET NW,
SUITE 211
ROCHESTER, MN 55901
(507) 388-2149

TOLL FREE #:
(877) 846-9259



TIMOTHY J. WALZ
CONGRESS OF THE UNITED STATES
FIRST DISTRICT, MINNESOTA
WWW.WALZ.HOUSE.GOV

AGRICULTURE COMMITTEE
ARMED SERVICES COMMITTEE
VETERANS' AFFAIRS COMMITTEE

August 11, 2015

**Ms. Linda Halliday
Office of Inspector General
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420**

Dear Deputy Inspector General Halliday:

I am writing today regarding recent media reports concerning a Department of Veterans Affairs Office of the Inspector General (VA OIG) investigation into the St. Cloud Veterans Affairs Medical Center (St. Cloud VA).

According a USA Today story published August 8th, 2015, the VA OIG closed an investigation into allegations of mismanagement and a culture of retaliation for whistleblowing at the St. Cloud VA in January, 2014. However, the article states the VA OIG did not make the findings of that report public, but a Phoenix whistleblower obtained a copy of the report.

I respectfully request you immediately release a copy of the report to my office and the appropriate Congressional Committees. I also ask that you make this report public and post it on your website. Finally, I would appreciate the answers to the following questions:

- 1. In the last few months, the VA OIG has publically released a number of closed reviews of whistleblower complaints. Why was the 2014 St. Cloud VA report not made public? What is the VA OIG's official policy for releasing these reports?**
- 2. How does a member of the public have a copy of the report if that report has not been made public? Was it leaked?**
- 3. In the last five years, how many complaints have you received regarding whistleblower retaliation and suppression at the St. Cloud VA?**

4. Based on the complaints you have received, do you believe there a pattern of whistleblower suppression in these allegations?

5. Are there currently any other VA OIG open investigations regarding retaliation and suppression at the St. Cloud VA?

If you have any questions or need more information, please contact Carina Marquez-Oberhoffner in my Washington, D.C. office at carina.marquez@mail.house.gov.

I appreciate your prompt attention to this matter and your quick response as we work to ensure veterans have access to the high-quality care they have earned.

Sincerely,

A handwritten signature in blue ink, appearing to read "Tim Walz", is written over a faint, circular official seal of the U.S. House of Representatives.

Tim Walz
Member of Congress



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

AUG 14 2015

The Honorable Tim Walz
United States House of Representatives
Washington, DC 20515

Dear Congressman Walz:

This is in response to your August 11, 2015, letter regarding a 2014 Office of Inspector General (OIG) Hotline case referral concerning staffing and management issues at the St. Cloud VA Health Care System in St. Cloud, Minnesota.

Enclosed is a redacted copy of the results of the OIG Hotline case referral results. We made minimal redactions in accordance with exemption (b) (6) of the *Freedom of Information Act*, which authorizes the withholding of information that, if disclosed, would invade another individual's personal privacy.

I will respond shortly to the five questions in your letter in separate correspondence; however, I would like to take this opportunity to provide some background information relevant to this case. The attached report was prepared and signed by the Acting Director, Veterans Integrated Service Network (VISN) 23 Primary and Specialty Medicine Service Line, based on a review conducted by a team from the VISN 23 Network, excluding any officials from the St. Cloud facility, in accordance with VA Directive 0701, *Office of Inspector General Hotline Complaint Referrals*. The review and report were not prepared or performed by the OIG. Because the OIG receives more complaints than we have the capacity to review, this directive established a process by which the OIG refers allegations to VA for an internal review by an official separate from and at a higher grade than the alleged wrongdoer(s). We will provide additional details regarding our information release process for OIG Hotline case referrals in our forthcoming letter.

Thank you for your interest in veterans and the Department of Veterans Affairs.

Sincerely,


LINDA A. HALLIDAY
Deputy Inspector General

Enclosure



Department of Veterans Affairs
VA Midwest Health Care Network
Veterans Integrated Service Network 23

2805 Dodd Road, Suite 250
Eagan, MN 55121
Phone: (651) 405-5600
Fax: (651) 452-0399



January 17, 2014

VA OIG HOTLINE DIRECTOR (53E)
WASHINGTON, DC
Hotline Case #2014-00459-HL-0044

Dear Mr.

This is in response to the allegations reported to the Office of the Inspector General regarding alleged problems with facility and services; alleged insufficient staffing and alleged managerial issues at the St. Cloud VA Health Care System.

An extensive independent review of these allegations was conducted by a five member team consisting of the VISN 23 Primary and Specialty Medicine Acting Director/Medical Director; VISN 23 HPDP/PACT Coordinator; Deputy Director Primary Care, Iowa City VA; Associate Director Patient Care Services/Nurse Executive, Sioux Falls VA and Associate Chief of Nursing, Primary Care and Specialty Medicine Service Line, Sioux Falls VA.

Specific review of the allegations was conducted through a detailed on-site investigation which included face-to-face interviews with senior leadership, PSM Service Line leadership, providers, nurses and clerks, as well as a review of relevant documents. Three individuals were identified in the complaint as people who would have specific information in regards to the complaint. Dr. and were interviewed; was not on station the week of the interviews... The team interviewed 34 individuals. All individuals invited that did not show for the interviews, were called and offered an alternative time. Individuals interviewed were instructed that additional information could be provided in writing to the team until January 10th.

During summer 2013, the St. Cloud VA Health Care System had five providers out of a total of twenty-one resign between July 31, 2013 and September 7, 2013. This appeared to be the inciting event for the complaint. Reasons for separations provided by Human Resources were one retirement, two relocations, and two as no reason given. Based upon provider interviews with those who remain and those who

have left, reasons for leaving were excessive workload and over paneling. Twenty-six primary care providers resigned between 2011 and 2013.

Below is a detailed listing of the allegations as listed in the complaint and results of the review:

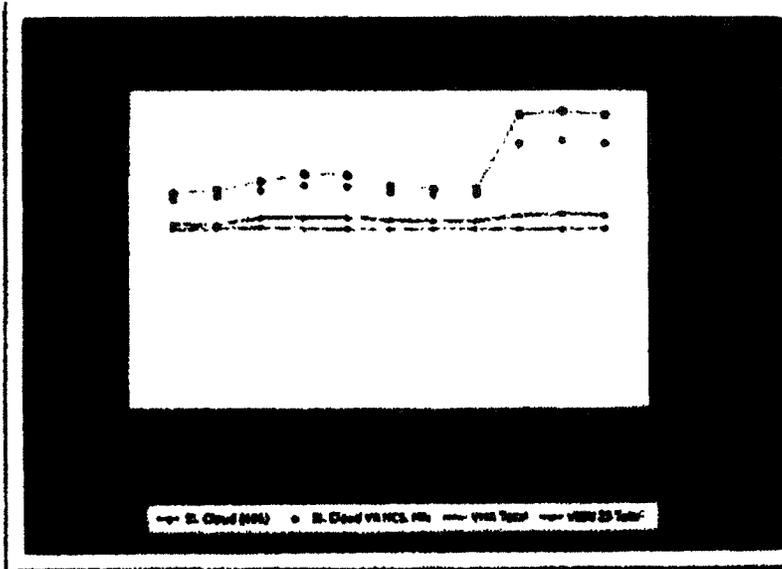
- ***Allegation #1: Many physicians and mid-level providers at the St. Cloud VAMC have recently resigned due to being treated in an "abusive and disrespectful manner by management."***
 - **Findings & Conclusions:**
 - **Many physicians and mid-level providers have recently resigned--Substantiated**
 - During summer 2013, the St. Cloud VA Health Care System had five providers out of a total of twenty-one resign between July 31, 2013 and September 7, 2013.
 - Reasons for separations provided by Human Resources were one retirement, two relocations, and two as no reason given.
 - Based upon provider interviews with those who remain and those who have left, reasons for leaving were excessive workload and over paneling.
 - Twenty-six primary care providers resigned between 2011 and 2013.
 - **Abusive manner by management--unsubstantiated.**
 - Interviews with multiple disciplines did not substantiate as evidenced by negative responses to direct questioning.
 - Team was unable to gather substantive evidence to support or refute this statement due to interviewing only a limited number of providers who left.
 - **Disrespectful manner by primary care management--unsubstantiated.**
 - Interviews with multiple disciplines predominately showed that the primary care medical director and nursing management were engaging, approachable, empathetic and supportive.
 - Examples were provided of multiple forums that facilitated interactions between front-line staff and these individuals.
 - **Disrespectful manner by senior management--substantiated.**
 - There were variations in responses received by PACT team members. We found teams that were very positive and ones that were extremely negative. However, on total, we received comments from more than one discipline 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. While facility leadership opined that any discontent was from a small group of disgruntle employees, the team found the fear of reprisal more pervasive among the employees in primary care.
 - Additionally, the 2013 all employee survey also supported the teams conclusions. (see below)
 - Notes from PSM service line minutes support the teams conclusions (see in particular September 2013 meeting minutes)
- A review of the 2013 All Employee Survey (AES) results for primary and specialty medicine showed the following:

Behavior	St. Cloud Overall	Overall PSM	VHA Administration	Physician	Nurse
Psychological Safety (disagreement)	3.27	2.8	2.79	2	2.98
Psychological Safety (comfort)	3.6	3.22	3.14	2.58	3.42

Allegation #2: As a result of the resignation of providers, panel sizes have grown to approximately 150% of recommended size.

Findings & Conclusions: Substantiated.

- A review of the panel sizes over the past three years revealed that the panel sizes were 110% of recommended prior to June 2013 and increased to 150% of recommended as of July 1, 2013.



- ***Allegation #3: The large panel size is threatening the Veterans' health and safety and providers are no longer able to provide proper care.***
Findings & Conclusions: Unsubstantiated.
 - Each person interviewed denied knowledge of patient care being compromised.
 - With the increase in panel sizes, staff did voice concerns about the amount of workload and fear of missing something.
 - PACT continuity data and CCHT utilization were unchanged. The 2 day post-discharge contact data showed a decline from 76.1% in June 2013 to 60.8% in September 2013. Trending from October 2012 through November 2013 on the PC Nexus report showed all measures were met except "AIC >9 or not done." It is recognized that this data is limited, since some trends may not yet have been apparent at the time of the review.
 - Peer review data showed no significant negative trends.
 - Patient complaints showed increasing number of complaints regarding frequent change of providers and slowed response to phone calls.
 - FY 2013 SHEP patient satisfaction access composite score did not show a significant change as evidenced below. This data analysis is limited, since the scores only represent Veterans who had an appointment.
SHEP Survey Composite Scores, FY'13
Q1: 47.4%
Q2: 45.2%
Q3: 43.2%
Q4: 44.8%
National average: 39.4%
- ***Allegation #4: Great numbers of appointments have been canceled due to insufficient staffing.***
Findings & Conclusions: Substantiated.
 - The DSS report showed canceled by clinic for St. Cloud 19.5% of all appointments compared to VISN 23 average (excluding St. Cloud,) of 12.08%. Overall cancellation rates for St. Cloud were 35.7% compared to VISN 23 average of 31.54%. No show rate was similar to VISN 23 average. (St. Cloud data did not break out the four sites of care, the main facility and three CBOC's). St Cloud care delivery site data, removing evening clinic and clinic of administrative providers, showed an average cancellation rate of 40.3%
 - Staff interviews supported the DSS data
- ***Allegation #5: Nurses are reviewing the resigned providers' orders to determine if the ordered clinic appointment is really needed.***
Findings & Conclusions: Substantiated.
 - Upon resignation of the providers, the registered nurses were instructed to review the upcoming Veterans' appointments and clinical needs. Based upon this review, the nursing staff forwarded any clinical concerns or questions for a higher level of review. When asked, "are you aware of any scenario where you felt you were practicing outside your scope," all denied with the exception of two nurses. Upon further probing, it was determined that the nurses were not acting outside of their scopes.

- The process above was also documented in the HR reply received for review by the team.
- The process was also partially documented in Aug. '13 PSM meeting minutes.
- **Allegation #6:** *Staff has to review many lab results, outside records, medication requests, etc., as it is afraid to miss something that could lead to Veteran's death.*
Findings & Conclusions: **Substantiated.**
 - Interviews confirmed that staff had "fear of missing something." When the providers left, staff reported that the Veterans stayed aligned with the remaining members of the team let for continuity until the Veteran was reassigned to a new panel.
 - **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.
- **Allegation #7:** *Facility management has responded to the short staffing by doing more of what caused the problem in the first place, as providers are being harassed and threatened with suspensions and other disciplinary actions.*
Findings & Conclusions: **Unsubstantiated.**
 - Review of documents for one provider's disciplinary actions are related to independent facts and not related to provider responses in discussion. There is also an [redacted], for a provider who was unavailable for interview.
 - Regarding facility management actions to resolve provider staffing shortage, the review confirmed that the facility's response was not proactive. Once initiated, however, it was robust and has resolved most of the provider staffing shortages. As of this review 5 providers have been hired, with full staffing anticipated by March 2014.

Mitigating action started by the facility leadership:

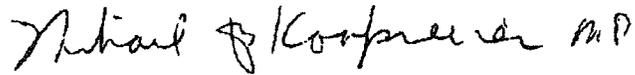
- Aggressive recruitment for primary care providers has taken place such that within the next 30-60 days, primary care staffing should allow for panel's sizes slightly less than 100% of calculated. (PACT data from November 2013 shows a panel size of 1417, down from a high of 1787 in August, but higher than the goal of 1276.)
- Retention efforts for existing and new staff have been pursued. A group of current providers suggested and with administration's agreement, new staff will be oriented slowly, and assigned a mentor to help ease them into the VA model of care. The current providers have agreed to accept higher panel sizes for a short period longer to achieve this goal.
- Facility Director and COS to meet regularly with primary care providers to increase visibility and improve communication.

Team recommendations to the facility:

- NCOD facility wide consultation.

- VISN leadership will monitor the facility's improvement actions until all findings are addressed.

The supporting documentation for this review will be available to the OIG upon request during the record retention period. If you have any questions or require more information, please contact me at



MICHAEL B. KOOPMEINERS, MD
Acting Director, VISN 23 Primary and Specialty Medicine Service Line
Medical Director, VISN 23 Primary and Specialty Medicine Service Line

7.

Documents Reviewed.

1. Original documentation from OIG, dated 11.1.2013 (OIG Hotline Referral Case No. 2014-00459-HL-0044 VA Directive 0701
2. 2012 All Employee Satisfaction Survey Results
3. 2013 All Employee Satisfaction Survey Results
 - a. Participation rates 59% compared to 65% FY'12 and 63% FY' 11
 - b. Primary Specialty Medicine service line compared to VISN 23 and VHA, scored 2 standard deviations below in 6 areas, work amount, direct supervision, senior management, praise, overall satisfaction, and organization satisfaction. The police department scored in similar range. When the results were broken down specific areas of note that were 2 standard deviations below comparison groups included, leadership, conflict resolution, psychological safety, civility, fairness, supervisory support and supervisor communication.
4. PACT Primary Care monthly Workload report, Yearly report, Calendar year 2013 (St. Cloud VA generated report)
5. PACT Primary Care monthly Workload report, Monthly report, Calendar year 2013(St. Cloud VA generated report)
 - a. 1st quarter of CY '13
 - i. Average appointment utilization low 90%
 - ii. Average patient seen per day, 8-9
 - b. 3rd quarter CY '13
 - i. Average appointment utilization low 99% to 100% (high of 115%)
 - ii. Average patient seen per day, 9-10 (high of 12)
 - iii. Number of "overbooks" double compared to 1st quarter
 - c. Oct. and Nov. CY '13
 - i. Average appointment utilization low 94% to 95% (high of 102%)
 - ii. Average patient seen per day, 9-10 (high of 11)
 - iii. Number of "overbooks" returned to level similar to 1st quarter

NB. [redacted] and [redacted] removed from analysis since they are the Service line Director and COS respectively

NB. Women's health also removed from the analysis above

6. Human Resources Officer, Response to information request from the review team including:
 - a. List of all providers who have left the facility in the last three years
 - i. FY'10, 9 provider left, 8 resignation or transfers, 1 termination
 - ii. FY'11, 10 providers left, 9 resignation or transfers, 1 retirement
 - iii. FY'12, 8 providers left, 1 death, 1 retirements, 6 resignation or transfers,
 1. 5 left between Aug. 22nd and Oct. 2nd
 - b. List of clinical providers disciplinary actions proposed during the last three years (including final disposition as appropriate)
 - i. 6 disciplinary actions were proposed during FY'11 to FY'13.
 - ii. 3 actions occurred in the last 6 months, which would be in the time frame reported in the complaint which would indicated possible retribution by administration
 1. 2 actions involved one provider who was interviewed
- NB. The team found no evidence of the above actions being done in retribution for the provider's stance with administration regarding work load issues
2. 1 action involved a provider who was on station for the interviews
- c. Copies of written protocols, policies, procedures or guidance used by the RN's to "scrub" clinic appointments
 - i. No written policy existed. "The process is left to the provider on each teamlet to determine how they prefer to have patients scrubbed based on their practice."
 - ii. The processed used by the teams was described and was consistent with the information received during the interviews. An RN reviewed the list of the panel of patients, including visit information, recommended changes were given to the clinic coordinator who presented the information to the "Nurse Administrator (Nurse Practitioner) or Service Line Director (Physician) for final review and approval. Appointments were then changed, or 'scrubbed' as appropriate."
 - d. Results of all employee survey---see above
 - e. Provider turnover rates, Data extracted from the "Turnover Cube in HR from Proclarity"

8.

i. As a facility the turnover rates for NP, PA and Physicians, for FY'10 to FY'13 were at or below the VISN 23 and national averages for all years

NB. The turnover rate for primary care at St. Cloud facility based clinic in three years was 25 voluntary departures (27 minus 1 death and 1 termination) compared to an average staff of 22

ii. Recruitment process from Oct. '13 to present have resulted in

1. 4 new providers having started
2. 2 to start in Jan '14
3. ?? to start in Feb '14

NB. When all providers are on board, the panel size will average ??? o???% of estimated panel size

7. Pact Steering Committee Minutes, April 17th 2013 to September 18, 2013
8. PSM Provider Meeting Minutes, CY'13
9. Medical Executive Board Minutes, CY'13
10. VISN 23 Nexus report, Oct. '12 to Nov. '13
 - a. No significant change in trends occurred during this period of time for the following composite, Diabetes Mellitus, Preventative, IHD, Tobacco, Behavioral Health, Frail Elderly, Women's Health,
11. SHEP Scores, Q1, Q2, Q3, Q4, for FY'14
 - a. No significant change in trends occurred during this period of time.
12. PACT Metric report from Oct '12 to Sept '13
 - a. Panel sizes averaged 110% of panel capacity from Oct. '12 to June '13
 - b. Panel sized rose to 150% of panel capacity from July '13 to Sept '13 at the St. Cloud facility
 - c. Pact Team continuity did not change during this time period
 - d. Pact Team 2 day post discharge calls trended down ward after July '13
 - e. Pact Team phone encounters to all encountered trended upward after July '13
 - f. UC utilization has trended much higher than VISN and VHA average through this period of time, 30% to 40%
13. Environment of Care Council Meeting minutes CY'13
14. Management Briefing, Primary and Specialty Medicine, FY'13
15. Patient Incident Reports, CY'13 were reviewed.
16. Customer Service Report to QLC FY'13
 - a. Overall trend of patient concerns decrease through out the year
 - b. PSM showed a significant increase in complaints Qrt. 4, mainly in the areas of access, request for information and physical comfort
17. Peer Review, FY'13 data was reviewed.
18. DSS clinic cancelation report
19. Documented provided by Dr. [redacted] during his interview