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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

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RELEASED

B-133044

March 4, 1976

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The Honorable Floyd K. Haskell
United States Senate

Dear Senator Haskell:

In your March 17, 1975, letter and subsequent discussions with your office, we were requested to obtain information on the following aspects of the administration of the Denver Veterans Administration (VA) Hospital:

--Emergency and monitoring procedures.

--Medical records system and physician access to records.

--Staff levels and qualifications of those rendering direct patient care.

You were particularly interested in these matters as they relate to ambulatory (outpatient) care. Ambulatory care has greatly increased at the Denver hospital because of (1) the hospital management's decision to emphasize such care as part of a test of a new patient admission procedure and (2) legislation increasing substantially the number of veterans eligible for such care. Because of the increased number of veterans being treated, the hospital's ambulatory care service has had problems of insufficient space and staff and inadequate operating procedures to handle the workload.

The increased volume of veterans receiving ambulatory care has also affected other hospital services, such as nursing and diagnostic support. The staff rendering direct patient care is well qualified, but the quality of both inpatient and ambulatory services provided was sometimes less than adequate because of insufficient staff, particularly nursing personnel and, to a lesser degree, physicians and technicians. We also observed problems in the hospital's medical records system.

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INTRODUCTION

The Denver VA Hospital is an acute short-term general medical, surgical, and psychiatric facility affiliated with the University of Colorado Medical School. The hospital has a total of 439 operating beds: 180 surgical, 141 medical, 76 psychiatric, and 42 neurological.

As of March 1975, the hospital was authorized a staff of 1,066 full-time equivalent employees. Nursing Service and Medical Administration Service had the most employees--319 and 114, respectively. The hospital's funding increased from $20 million in fiscal year 1973 to about $24.5 million in fiscal year 1975.

AMBULATORY CARE

Veterans who have medical disabilities incurred or aggravated in the line of military duty are entitled to all reasonable medical services, including ambulatory care, necessary to treat the service-connected disabilities. Public Law 93-82, enacted in August 1973, authorized ambulatory care for non-service-connected conditions if the veteran were unable to defray the expense of necessary care and if such care would obviate the need for hospital admission. Before this legislation, ambulatory care could not be provided to such a veteran unless such care was (1) reasonably necessary in preparation for a scheduled hospital admission or (2) an extension of treatment received while hospitalized.

Ambulatory care consists of care in a primary care clinic, specialty clinics, and the emergency room.

A primary care clinic is the point of entry for a patient into the health care system. It is staffed by full-time VA physicians and nurse clinicians who initially evaluate a patient and select a mode of treatment--admission to the hospital, treatment as an outpatient, or referral to other hospital services for additional evaluation or treatment.

You were specifically interested in the access to patient records by physicians who respond to calls for medical help or advice. Such calls are referred to a physician in a primary care clinic except at other than normal working hours, when a physician in the emergency room takes the call.

Medical records of patients telephoning for help are generally not consulted by a physician at the time of the call. Rather, the physician makes immediate medical judgments by asking pertinent questions and listening to the caller's response. This is normal medical practice.

Specialty clinics provide care for outpatients, generally as an extension of treatment received while hospitalized. Care is provided in such specialties as hematology, cardiology, neurology, dermatology, podiatry, orthopedics, general surgery, and plastic surgery. Specialty clinics are generally staffed by physicians enrolled in residency programs and are open to patients at least once a week. The Chief of Ambulatory Care has administrative responsibility for specialty clinics, but the inpatient service chiefs are functionally responsible for them.

Primary care and specialty clinics are the means for monitoring outpatients with serious health problems. Appointments to these clinics are sometimes made as much as 6 months in advance. However, patients are also told to come in whenever they feel that it is necessary.

The Chief of Ambulatory Care stated that, although the emergency room is capable of providing services to some emergency medical cases, such as cardiac, pulmonary, and renal complications, the hospital does not have a true emergency room. The emergency room is more of an admitting office or an extension of the primary care clinic and is not equipped with personnel, physical facilities, or equipment with which to manage major trauma cases.

The emergency room is staffed by primary care physicians and nurse clinicians during the day. Night, weekend, and holiday coverage is provided by fee-basis physicians, referred to as admitting officers-of-the-day, who are generally licensed residents from the University of Colorado Medical School. They make medical judgments concerning a patient's need for hospitalization. They can also call on medical and surgical officers-of-the-day, who are also on duty in the hospital on nights, weekends, and holidays. These physicians are primarily responsible for inpatient care but are also available for consultation and assistance. An admitting officer-of-the-day can also request the assistance of on-call physicians for various specialties.

Peer review systems for ambulatory care

The VA central office has established a formal peer review system for reviewing care provided to inpatients and outpatients. This system had not yet been implemented for ambulatory care when we completed our review in November 1975. In the interim, the Denver hospital had established its own procedures for reviewing the quality of ambulatory care. In describing the review system, the Chief of Ambulatory Care stated that

--he reviews about 1 of every 10 medical records for the quality of care rendered,

--he and other house staff act as consultants to other physicians, and

--service chiefs and faculty supervise residents in the specialty clinics.

The Chief of Staff and Chief of Ambulatory Care informally review the treatment given in the emergency room. The Chief of Staff reviews treatment that the admitting officers-of-the-day give during weekends and holidays to patients not admitted to the hospital, and the Chief of Ambulatory Care provides the same review of treatments they give during weekday nights. Formal records of this process have been maintained since May 1975.

We reviewed 33 patient records relating to treatment rendered by the admitting officers-of-the-day and considered the treatment adequate in 31 of the cases. In the other two cases the patient records indicated that additional tests should have been performed. We discussed these cases with the Chief of Staff, who agreed with us.

Growth of ambulatory care workload

Beginning in November 1972, before passage of Public Law 93-82, the hospital undertook a test of new patient admission procedures. Although not an objective of the test, the ambulatory patient workload was increased at the hospital.

The VA central office provided over $245,000, including funds for 20.5 full-time equivalent positions, to support the test. With these additional resources, the hospital not only implemented the admission test but expanded its ambulatory care services. Veterans previously sent home without treatment because of ineligibility were offered evaluation, and either ambulatory or inpatient treatment, where appropriate. Under this liberal interpretation of the test procedures by hospital management, whenever questionable cases arose, ambulatory care was provided.

As a result, the hospital expanded from an institution primarily concerned with inpatient care to one concerned with ambulatory care as well. The VA central office was aware of the direction the hospital was taking; it advised hospital management not to expand beyond the capability of hospital resources because ambulatory care was not an objective of the test nor was the test funded for it.

The increase in ambulatory care workload at the hospital is shown in the following table:

Outpatient Medical Staff Visits

Fiscal year	Number of visits	Percent increase over previous year	Cumulative percent increase
1972	69,135	2.7	2.7
1973	74,952	8.4	11.1
1974	94,754	26.4	37.5
1975	117,326	23.8	61.3

In September 1973 the hospital director requested about $800,000 in additional funds to (1) support ambulatory care and (2) lessen the impact that the increased ambulatory care workload was having on inpatient care activities. The requested funds included an additional 24.5 positions for ambulatory care and ancillary services and 12 positions for inpatient services. The hospital received $40,000 toward the increase in ambulatory care workload and $110,860 to purchase expendable supplies. In November, hospital officials, lacking sufficient funding, unsuccessfully attempted to cut back the ambulatory care workload. According to the assistant hospital director, once the hospital opened its

doors to treat all veterans, they began to expect the service and terminating it became impossible.

Problems caused by expansion of ambulatory care program

In looking at the areas specified in your letter, we noted other problems which inhibited the delivery of ambulatory care. The increase in the number of eligible veterans and the expansion of ambulatory care caused the hospital to experience space, staffing, and operating problems.

Space

The physical design of the hospital was not conducive to handling large numbers of outpatients. Until July 1975 the ambulatory care section had only one waiting room, which was not centrally located. Because patients sat along hallways adjacent to examination rooms and because of heavy staff traffic, the area was heavily congested and appeared disorderly. The addition of a more centralized waiting room in July 1975 alleviated this situation. Also, a new two-story building adjacent to the hospital was opened in June 1975, thereby permitting expansion and remodeling of existing space to better accomodate ambulatory care activities.

According to the Chief of Ambulatory Care, a shortage of examining rooms in the primary care clinic is a continuing problem. He said that the present 9 rooms would have to be increased to 14 to permit efficient delivery of care.

Staffing

The Chief of Ambulatory Care said he has had problems recruiting ambulatory care physicians. During fiscal year 1974 and much of fiscal year 1975, the primary care clinic had, on the average, only five of its seven authorized physicians. According to the Chief of Staff, the ambulatory care staff was unable to adequately cope with the workload. In addition, the Medical Administration Service, which provides administrative support for ambulatory care activities, had a staff shortage which adversely affected admitting officer-of-the-day coverage.

Medical administrative assistants are in charge of hospital administration during other than normal duty hours. They are assisted by clerks during certain shifts

but are the only administrative personnel on duty from midnight to 7 a.m. The Assistant Chief of the Medical Administration Service stated that the medical administrative assistant is often needed to process applicants for treatment, identify emergency cases, answer two telephones, monitor the emergency radio, and locate medical records for emergency cases enroute to the hospital. Because of the randomness of these events, there is no way to put them in any priority that would allow them to be handled by one individual.

In May 1975 the Chief of the Medical Administration Service requested nine additional medical administrative assistant positions to provide total service to ambulatory care 24 hours a day, 7 days a week. The request was based on, among other things, increased patient load and adminstrative duties which made coverage by one person from midnight to 7 a.m. inadequate.

In July 1975 the Service's employment ceiling was increased from 109 to 120. However, none of the additional positions improved Service coverage from midnight to 7 a.m. because of other priorities.

Operating procedures

Hospital officials indicated that a number of problems with operating procedures have hindered ambulatory care. In January 1975 the Chief of Ambulatory Care informed management of problems in medical record retrieval, nonavailability of X-ray and laboratory reports when needed, excessive patient loads, and heavy patient loads in specialty clinics that caused long delays in scheduling appointments and referrals from the primary care clinic.

In a June 2, 1975, memo to the hospital director, the Chief of the Medical Administration Service stated that major problems existed in patient scheduling, staff scheduling, and medical records. The extent of these problems was difficult to assess. However, the Chief stated that the high rates of "no-shows" for appointments and "drop-ins" for treatment, 26 and 35 percent respectively, are caused by the above problems. The memo also stated that, for ambulatory care, there was a lack of firm policies and procedures, meaningful management information, and centralized leadership and a maldistribution of resources.

In October 1975, ambulatory care activities were organizationally placed under the Medical Service. The hospital

director believes that the reorganization will improve the delivery of ambulatory care. He stated that a new management analyst position was created in the Medical Service at the time of the reorganization. The analyst's function will be to analyze ambulatory care operating procedures, identify problems, and suggest corrective actions. Management expects improved administrative support as a result of this analysis.

Effect of ambulatory care growth on inpatient services

The growth of ambulatory care also affected the delivery of inpatient care at the hospital. Along with the greater activity in ambulatory care, hospital admissions and patient turnover increased and the length of hospitalization decreased, as shown below:

Inpatient Statistics

Fiscal year	Average daily patient census	Admissions to hospital	Average length of stay	Percent of turnover (note a)
1972	335	6,941	17.5	173.6
1973	359	9,976	13.5	230.8
1974	363	10,243	12.9	235.3
1975	360	11,457	11.4	265.2

a/ $\frac{\text{Discharges from hospital}}{\text{Average daily patient census X 12 months}}$ X 100%= Percent of turnover

These statistics reflect the screening process performed by ambulatory care physicians. The veteran with a nonservice-connected disability need no longer be hospitalized to be eligible for medical treatment; he is now treated as an outpatient. This reduces the number of nonseriously ill patients occupying hospital beds. Also, the screening process has resulted in many more seriously ill patients being admitted to the hospital now than before. Many require more intensive, direct nursing care. In addition, these patients don't remain in the hospital as long as before; they are transferred to ambulatory care as soon as medically feasible. As a result, nursing care requirements of hospital inpatients have intensified.

ADEQUACY OF NURSING STAFF

At the time of our review, the nursing service consisted of 340 full-time equivalent employees--185 registered nurses, 152 licensed practical nurses and nursing assistants, and 3 clerical personnel. The nursing staff appeared to be well qualified. More than 50 percent of the nurses were registered nurses, of which about 40 percent had their bachelor's or master's degrees in nursing or were working toward their master's degrees. The hospital conducts continuing classroom and in-service training for all nurses.

Denver hospital management and VA central office nursing officials agreed that (1) the above staffing level was significiantly less than necessary to provide adequate nursing care and (2) in some instances, less than adequate nursing care has been provided.

During the budgetary processes for fiscal years 1974-76, the Denver hospital consistently reported to the VA central office that it needed a total of from 407 to 430 nurses. During the 3 years, the hospital's requests for additional nurses were revised downward significantly by the central office. Sixty-five additional nursing positions were authorized during the 3-year period, half of which were for special units or new programs, leaving the balance for assignment to hospital wards.

The hospital's position that it needs more nurses is supported by the central office's March 1975 internal nurse staffing guidelines. These guidelines indicate a nursing staff of from 382 to 419 is required at the Denver hospital. Thus, according to the guidelines, there is a shortage of from 42 to 79 nurses (from 11 to 19 percent).

Because of the staff shortage, nurses are often unable to adequately care for patients. According to the Chief of Nursing Service and other nursing personnel, the staff shortages and the intensified nursing care requirements of may ward patients resulted in the following conditions:

--Nurses are not always able to follow a physician's order prescribing the frequency of patient treatment or medication. Treatments are sometimes given late or missed entirely.

--Surgical dressings are often changed late or not changed at all, increasing the chances of infection.

--Such vital signs as temperature, pulse, and blood pressure are not checked as often as required or not checked at all.

--Patients are not always turned or ambulated as frequently as required to alleviate bed sores.

--Nurses are unable to properly attend to their patients' psychological, emotional, and personal hygiene needs.

In addition, nurses said they are often unable to properly educate their patients or the patients' families about post-discharge self-care responsibilities. They were concerned that discharged patients often "get into trouble" before their first followup clinic visit and that the lack of proper patient education before discharge may increase the hospital's readmission rate.

The nursing shortage has also made it difficult for the hospital to properly staff patient care areas around-the-clock. Efforts made to provide nursing coverage include having nurses work 12- or 16-hour shifts and work on days off. In addition nurses are often "pulled" from one ward to cover a nurse shortage in another.

Nursing personnel said they feel frustrated and dissatisfied over being unable, because of staff shortages and intense workload pressures, to properly care for their patients. According to the Chief of Nursing Service, these problems manifest themselves in absenteeism and turnover. The quit rate for registered nurses at the Denver hospital for fiscal year 1975 was 19 percent, compared to the VA-wide rate of 12 percent.

Many of these problems were observed and reported to the central office Director of Nursing by the VA Deputy Director of Nursing after her visit to the hospital in August 1974. The Deputy Director recommended that planned 16-hour shifts for nurses and "pulling" nurses from one ward to cover a shortage in another be eliminated; however, she did not suggest any alternatives. The hospital continued these practices as late as September 1975.

ADEQUACY OF TECHNICIAN, PROFESSIONAL, PHYSICIAN, AND DENTAL STAFF

During our review, the hospital employed 222 technicians and professionals, such as social workers and speech therapists; 28 full-time and 61 part-time staff physicians, and 104 residents. A review of a sample of individuals' credentials disclosed, with one exception, a well-qualified staff.

An analysis of the credentials of the hospital's physician and dental staff disclosed that 88 out of 93 staff members were either board certified or board eligible. Board certification or eligibility is a generally accepted standard of measuring a physician's or dentist's qualifications.

VA regulations allow the qualifications of residents to be determined by affiliated hospitals. The hospital, therefore, relies upon established specialty board prerequisites and the accredited curriculum of the affiliated medical school to insure high-caliber, qualified residents.

We reviewed the qualifications of the 10 residents who performed admitting officer-of-the-day duties in April 1975. Nine held M.D. degrees; the other held a doctor of osteopathy degree. All had completed a 12-month internship after graduation. Six had postgraduate training in internal medicine, two in surgery, one in neurology, and one in family practice.

The exception noted was that the University of Colorado Medical Center supplied unlicensed anesthesiologists to the hospital in violation of a contract between the two parties. In April 1975 hospital management requested that the VA central office authorize a deviation from the licensure provision of the contract; in June the Chief Medical Director denied the request. Hospital management later obtained an oral assurance from the medical school that it would supply only licensed anesthesiologists in the future. However, the school continued to supply unlicensed personnel. The hospital Chief of Staff has said that the use of unlicensed anesthesiologists does not compromise the quality of patient care; rather, that it is a matter of legality with respect to VA personnel procurement regulations. In October 1975 he advised the school that the hospital can no longer accept the services of unlicensed anesthesiologists. The school subsequently sent only licensed anesthesiologists to the hospital.

There are no standards to measure the sufficiency of technical, professional, physician, and dental staff levels. Therefore, we obtained the opinions of 15 service chiefs, whose organizations provide direct patient care, regarding the sufficiency of their present staff levels.

Ten chiefs said that they needed a total of 15 more physicians and other professionals, such as social workers, and a total of 14 more technicians, such as laboratory technologists. The other five chiefs said their present staffs were sufficient. Service chiefs citing shortages based their needs on properly meeting the patient care workload as of August 1975 rather than on meeting future workloads or staffing new programs.

Eleven of the 15 services had procedures for providing around-the-clock, seven-day-a-week coverage. The coverage was furnished by either scheduling full, 24-hour shift coverage or by using an on-call procedure for nights, weekends, and holidays. The other four services, which provide nonemergency care, such as dental and audiology service, treat patients from 8 a.m. to 4:30 p.m., Monday through Friday.

During our review, coverage procedures on one surgical subspecialty section broke down. For several days patients of the section were not seen by a physician. After we advised the Chief of Staff of the incident, he wrote a letter of admonishment to the physician in question and took steps to prevent a recurrence.

MEDICAL RECORDS

Medical records are particularly important in the VA system because patients do not have personal physicians--both inpatients and outpatients are treated by many different staff physicians and residents. Under this system, the importance of maintaining current and complete medical records for every patient is recognized by VA central office and Denver hospital officials. Nevertheless, procedures to assure timely availability and complete medical records at the Denver hospital were neither complete nor adequately enforced.

Medical record preparation and processing requires input and coordination from both professional and administrative services to achieve accurate and timely execution and disposition of medical records.

Professional responsibilities

Professional responsibilities for medical records include furnishing information regarding the patient's history, examination and diagnoses, description of all medical and surgical procedures performed, progress notes, and a summary of hospitalization. The VA Chief Medical Director emphasized the importance of this information in a January 1975 letter to hospital directors, wherein he stated that incomplete and unavailable medical records are a severe hindrance to providing high quality treatment.

VA policy requires that patient hospital summaries be completed (dictated, transcribed, and signed by attending physicians) within 10 days after discharge. A statistical sample of patients discharged during August 1975 showed that between 81 and 88 percent of the summaries were dictated within 10 days of discharge. Staff physicians and residents were much less timely, however, in signing summaries. Only 42 percent of the transcribed summaries were signed by the 10th day after discharge, 44 percent were delinquent from 1 to 20 days, and the other 14 percent were delinquent over 20 days.

Signing hospital summaries is important because it verifies the accuracy of the summary and initiates other processes which result in the record eventually being filed. Records should be filed as soon as possible because about 65 percent of all patients discharged from inpatient care return to outpatient clinics within several days. Hospital summaries, which should be available at that time, are often not a part of the medical record because they have not been signed.

Although a high percentage of summaries of patients discharged during August 1975 were dictated within 10 days, the workload of records awaiting summary dictation on a particular day in September 1975 indicated a buildup of delinquent records. Of the 260 records in the universe on that day, 88 percent had exceeded the 10-day VA standard. The number of days by which the standard was exceeded ranged from 1 to over 350, thereby increasing the chance for error when the summary was finally dictated.

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Medical record preparation and processing requires input and coordination from both professional and administrative services to achieve accurate and timely execution and disposition of medical records.

An important standard, which determines the ability to deliver a record where needed in a timely manner, is to maintain adequate control over and followup of loaned records. The file unit uses a file charge-out system, but this system does not readily identify those records not returned. Therefore, it cannot be readily determined which records have not been returned to file or how long they have been on loan. Under the present charge-out system, surveying file shelves for charge-out cards to follow up on those not returned would be a monumental task. Further, our analysis showed that locating records took a great deal of effort and time and the assistance of numerous hospital personnel. We found that

--many records could not be located where entries on charge-out cards indicated they should be and

--some records were in locked rooms and desks, on top of lab tables, stacked on floors, or at an affiliated hospital.

The Chief of Medical Administration agreed there was lack of control over and followup of loaned records. He said that a lack of time, absenteeism, low-grade positions in the file room, and demands of meeting daily workloads precluded establishing a better control system.

The medical record file unit had problems in obtaining and retaining staff. According to VA central office criteria, the staffing level for the file unit should have been 11.5 full-time equivalent employees. During fiscal year 1975 staffing ranged from five to nine employees. According to the hospital director, mechanized equipment is needed in the file room and has been requested from the central office. He added that he had kept staffing below authorized levels in anticipation of acquiring the needed equipment.

Hospital officials were generally aware of the medical record problems described above and said they have taken actions to improve the timeliness of dictating and signing hospital summaries and to make these complete records more readily available.

CONCLUSIONS

The increased ambulatory care workload lessened hospital management's ability to efficiently provide care to all

veterans requesting treatment. The increase caused problems in space, staffing, and operating procedures of the ambulatory care program. These problems may manifest themselves in the high incidence of "no-shows" for appointments and "drop-ins" for treatment.

Although the staff rendering direct patient care is well qualified, the staffing level of the nursing service is significantly less than that required to provide adequate nursing care to patients. This is also true, to a lesser degree, for physicians, technicians, and other professionals.

VA standards and policy for preparing and controlling medical records appear to be adequate, but these standards and policies have not been properly implemented at the Denver hospital.

RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

We recommend that the Administrator:

--Instruct the Denver hospital director to analyze ambulatory care operating procedures to identify ways of reducing the high incidence of "no-shows" for appointments and "drop-ins" for treatment.

--Reassess the staffing requirements of the Denver hospital to determine the staffing necessary to deliver an adequate level of patient care. If additional staff resources cannot be provided, the operating bed capacity of the hospital should be reduced.

--Instruct the Denver hospital director to monitor the implementation of procedures, consistent with VA standards, for preparing and controlling medical records.

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As you requested, the Veterans Administration has not been asked to formally comment on the information contained in this report; it has, however, been discussed with VA central office and Denver hospital officials and their comments have been recognized where appropriate in this report.

This report contains recommendations to the Administrator of Veterans Affairs. As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the House and Senate Committees on Government Operations not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report. We will be in touch with your office in the near future to arrange for release of the report so that the requirements of section 236 can be set in motion.

Sincerely yours,

Comptroller General
of the United States