



DEPARTMENT OF VETERANS AFFAIRS  
UNDER SECRETARY FOR HEALTH  
WASHINGTON DC 20420

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Charlene S. Ehret, FACHE  
Director  
James H. Quillen VA Medical Center  
P.O. Box 4000  
Mountain Home, TN 37684

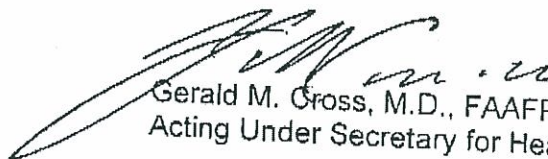
Shiryll L. Durham,  
President, AFGE Local 1687  
James H. Quillen VA Medical Center  
P.O. Box 518  
Mountain Home, TN 37684

Dear Ms. Ehret and Ms. Durham:

I am responding to the issues raised in Ms. Ehret's memoranda of January 14, 2009, concerning the American Federation of Government Employees (AFGE), Local 1687 Unfair Labor Practice (ULP) Charge over the change in tours of duty for the Community Living Center (CLC) physicians who were placed on a rotating on-call roster coverage of CLC patients after normal duty hours and weekends.

Pursuant to delegated authority, I have decided, on the basis of the enclosed paper, that there is insufficient information to make a determination that the issue presented in the ULP is a matter concerning or arising out of professional conduct or competence (direct patient care) within the meaning of 38 U.S.C. § 7422(b). As a result, the issue presented by the ULP is within the scope of collective bargaining.

Sincerely yours,

  
Gerald M. Cross, M.D., FAAFP  
Acting Under Secretary for Health

Title 38 Decision Paper  
VA Medical Center, Mountain Home, TN

VA -- 09-0

FACTS:

On October 15, 2008, an adverse patient outcome occurred at the Mountain Home, TN VA Medical Center's (VAMC) Community Living Center (CLC) and an investigation started immediately.<sup>1</sup> An internal Peer Review and an external VISN investigation revealed the VAMC was in violation of the American College of Graduate Medical Education guidelines with respect to safe clinical coverage for patients in the CLC. The Chief of Staff determined the best option to ensure safe clinical coverage was to place CLC physicians on a rotating on-call roster of CLC patients after normal duty hours and weekends.<sup>2</sup>

During a meeting scheduled for November 18, 2008, the Chief of Staff instituted the following guidelines to ensure safe clinical coverage for the CLC:

"a. When the CLC Physicians are scheduled for the weekend coverage, they will be provided with a compensatory day off the following week. This day will be scheduled with the [Associate Chief of Staff] ACOS Extended Care prior to the weekend.

b. When the CLC Physicians are designated to cover a weekday on-call following the end of their normal tour of duty from 4:30 pm until 8 PM, they are not to report to duty until 11:30 on the day scheduled for evening on call."

The guidelines were to remain in effect until new hospitalists could be hired to provide on call coverage for the CLC during all after hours and weekend shifts."

On or about November 3 or 4, 2008, the ACOS Extended Care had a discussion with the CLC Physicians regarding the above mentioned adverse patient outcome, and informed them that they would be placed on a rotating schedule to take calls from home via beeper to handle any and all crisis issues. These physicians would be provided VA laptops with VPN access to provide safe clinical coverage after normal duty hours and on weekends. It is important to

<sup>1</sup> The event involved a patient transferred from a medical/surgical/oncology inpatient unit Ward C Ground (Ward CG) to the CLC. The patient received too much insulin in the CLC and the resident on call who responded to the CLC nursing staff's call did not address the error. The patient was subsequently transferred to the Emergency Department (ED) where the error was discovered by the ED staff. Once stabilized, the patient was transferred to Ward CG where he expired on October 25, 2008.

<sup>2</sup> There was no documentation presented to support this paragraph. The information comes from paragraphs 2 and 3 of the request to the USI for a decision that the referenced issues are non-negotiable pursuant to 38 U.S.C. § 7422. (Attachment 3)