



DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

DEC 17 2004

In Reply Refer To:

Director (00)
VA Northern Indiana Health Care System
1700 East 38th Street
Marion, IN 46953

Re: Collective Bargaining Agreement Re "Impact and Implementation
Demands for Hospitalist Proposal"

Dear Mr.

I am informed that you have requested a determination by the Under Secretary for Health that 38 USC § 7422 bars a grievance filed by the local AFGE union alleging, among other things, violation of a 2001 agreement entitled "Impact and Implementation Demands for Hospitalist Proposal." Review of this agreement in connection with your request indicates that the agreement itself involves a number of direct patient care issues and is therefore non-negotiable under 38 USC § 7422(b). I am writing to re-iterate that labor-management relations specialists and Regional Counsel must be consulted whenever facility management engages in collective bargaining on issues relating to Title 38 medical professionals.

Sincerely yours,

A handwritten signature in cursive script, reading "Laura J. Miller", is positioned above the typed name.

Laura J. Miller
Deputy Under Secretary for Health
For Operations and Management



DEPARTMENT OF VETERANS AFFAIRS
UNDER SECRETARY FOR HEALTH
WASHINGTON DC 20420

DEC 17 2004

Director (00)
VA Northern Indiana Health Care System
1700 East 38th Street
Marion, Indiana 46953

Dear

I am responding to your memorandum of August 30, 2004, concerning a grievance filed by AFGE Local 1020 over management's scheduling of patients during time normally reserved for physicians' administrative activities.

Pursuant to delegated authority, I have determined, on the basis of the enclosed decision paper, that the issue presented is a matter concerning or arising out of professional competence or conduct and is thus exempted from collective bargaining by 38 USC § 7422(b). In addition, I have determined that the parties' May 10, 2001 memorandum of understanding regarding scheduling of patients involves issues of professional conduct or competence, specifically impacting direct patient care, and is therefore non-negotiable under 38 USC § 7422(b).

Please provide this decision to your Regional Counsel as soon as possible.

Sincerely yours,

A handwritten signature in cursive script, appearing to read "Jonathan Perlin".

Jonathan Perlin, MD, PhD, MSHA, FACP
Acting Under Secretary for Health

Enclosure

**Title 38 Decision Paper -- VA Northern Indiana Health Care System
VA -04 -13**

FACTS

a. The Grievance

This matter arises out of a grievance (Attachment A) filed by the American Federation of Government Employees (AFGE) Local 1020 alleging that management at the Marion Division of the VA Northern Indiana Health Care System (VA NIHCS) violated both a past practice and a written agreement provision in scheduling patients to be seen by a Primary Care physician during hours normally reserved for physicians' administrative activities.

The union alleges in the grievance that management violated a past practice of providing hour-long educational opportunities for all clinical staff on Wednesday mornings from 8:00 am to 9:00am. While the training is not mandatory, patient appointments are not routinely scheduled during this time period so that staff may attend and participate in these Continuing Medical Education (CME) sessions. The union thus argues that affording each physician a one-hour CME opportunity each Wednesday morning is a past practice that management may not unilaterally terminate.

The grievance also alleges that management violated a written memorandum of understanding (MOU) regarding the scheduling of patients in Primary Care. (Attachment B.) The MOU, which was signed on May 10, 2001, by the Chief of Primary Care and the Executive Vice President of the local union, provided (among other things) that Primary Care physicians would have patient-free time on Tuesday afternoons as an "administrative work schedule," and that management would "ensure that provisions are made for scheduled absences as much as possible so those physicians do not lose this time dedicated to administrative work."¹

In mid April 2004, Dr. _____, a Primary Care physician, requested sick leave for April 20 and April 26, 2004. VA NIHCS management was able to reassign Dr. _____ patients on April 20 to other practitioners in order to maintain patient care and to avoid the need to reschedule the patients. However, the patients whom Dr. _____ had originally been scheduled to see on April 26 could not be reassigned to other providers; those patients were rescheduled to see Dr. _____ during time slots that had been set aside for administrative activities. More specifically, two of Dr. _____ patients from April 26 were rescheduled on Wednesday between 8-9AM, the normal CME time, while a third patient

¹ The rest of the MOU's terms are detailed in part b. below.

was rescheduled during the Tuesday afternoon slot normally set aside for administrative work under the above-quoted contract provision.²

On May 10, 2004, the union filed its grievance alleging that management had violated the MOU and past practice by assigning Dr. [redacted] patient clinic visits during times he had regularly been scheduled for CME and/or administrative time. (Attachment B) The union also alleged, without explanation, violations of Articles 1, 16, 32 and 46 of the parties' Master Agreement³. As a remedy, the union demanded that management 1) immediately return Dr. [redacted] CME and administrative time to him; 2) develop and implement a plan (with AFGE concurrence) to cover both planned and unplanned leave by the Medical staff; and 3) cease and desist in the above noted changes in working conditions for the affected bargaining unit employees. Further, the union demanded in the grievance that management discuss changes in working conditions with the union pre-decisionally and negotiate as appropriate with the union for any proposed changes in working conditions.

On June 1, 2004, the Chief of Primary Care responded to the grievance, stating that the assignment of patient care duties superseded Dr. [redacted] right to attend an educational opportunity or complete paperwork, and further that the grievance was excluded from the negotiated grievance procedure under 38 U.S.C. 7422. (Attachment C)

On June 11, 2004, the union vice president sent the Chief of Primary Care an email requesting a stay in the grievance process so that the matter could be forwarded to the Under Secretary for Health (USH) for a determination as to whether the matter involved professional conduct or competence within the meaning of 38 U.S.C. 7422(b). (Attachment D)

By memorandum dated August 30, 2004, the Director of the VA Northern Indiana Health Care System referred the matter to the USH for a determination as to whether the matter is outside the scope of collective bargaining and therefore non-grievable because it meets one of the exclusions in 38 U.S.C. 7422(b). (Attachment E)⁴

b. The MOU

As noted above, the parties entered into an MOU relating to scheduling of patients in the Primary Care Clinics on May 10, 2001. The MOU, by its terms, provides as follows:

² Management has explained that it rescheduled Dr. [redacted] patients in this way "in an effort to meet a management objective of timely addressing patient care needs within two weeks of the original scheduled appointment date." (See Attachment E, paragraph 5.)

³ Article 1 of the AFGE Master Agreement deals with Recognition and Coverage, Article 16 with Employee Rights, Article 32 with Time and Leave, and Article 46 with (Union) Rights and Responsibilities. When VAMC Marion management requested this 38 USC 7422 determination, the local union was provided an opportunity to submit an explanation of its grievance to the Under Secretary for Health (USH); but the union declined to do so.

⁴ Prior to sending this memorandum to the USH, management provided a draft to the union and solicited the union's comments for inclusion in the final memorandum. The union provided no comments.

1. The Hospitalist will cover the inpatient psychiatry wards on Building 185 on a consultation basis. The Hospitalist rotation will be matched up to the Medical Backup rotation. Weekend routine will remain the same for the Medical Backup physician. Dr. _____ is the exception and his Backup week will be covered by rotation.

2. The Primary Physicians will maintain their one half day administrative work schedule (except for Dr. _____ who has two half days) to complete paperwork and review tests, labs, and renew medications et al. Management will ensure that provisions are made for scheduled absences as much as possible so those physicians do not lose this time dedicated for administrative work. There will be no more than 11 primary care patients scheduled for the day of a physician's administrative half-day.

3. Any patients rescheduled as a result of a Hospitalist schedule for Primary Care will be distributed in the clinics without overbooking. This may be accomplished in consultation with each individual physician.

4. No more than 18 patients will be scheduled for each full day Primary Care Clinic. Any overbooks beyond this will be left up to the discretion of each individual physician for his or her own clinic. The 10 AM and 2 PM time slots are not overbook slots but are appointments that are used by patients that need to return soon. These appointment slots may only be filled at the individual physician's discretion.

New patient clinics will be scheduled on a fair and equitable basis between all the clinics.

5. Dr. _____ will be exempt from the Hospitalist coverage due to her part-time status.

6. The start date and rotation (in accordance with the Medical Backup rotation) will be implemented July 2, 2001.

7. The methods, means and technology to determine the assignment and working conditions of the new physician coming in June 2001 for [sic] will be discussed and negotiated appropriately prior to assignment.

Conclusion: The new physician will take part in the backup and hospitalist rotation schedules. This physician will see the majority of new patients coming to the Marion Division of VA NIHCS until her panel reaches parity with the other clinics. Her clinic will have a planned date in advance of when she will reduce the number of new

patients in her clinic to avoid scheduling patients far in advance after the clinic has reached full capacity (parity with the other primary care clinics).

8. When physicians are on leave, medications renewal and administrative paperwork to be completed as is the current practice, by one of the physicians on their particular team.

9. The Hospitalist coverage plan will be reviewed no later than January 2002 in order to make any changes, revisions, or to consider other alternatives to this plan.

10. The Hospitalist Plan may be renegotiated at the request of either party at any time after implementation.

APPLICABLE VA REGULATIONS:

The VA Secretary is authorized by 38 USC § 7421(a) to "prescribe by regulation the hours and conditions of employment and leaves of absence" of Title 38 employees, including physicians. The Secretary has exercised this authority by promulgating regulations in VA Handbook 5005 pertaining to physicians' hours of duty and leave. These regulations include the following:

VA Handbook 5005, Part II, Chapter 3:

2. BASIC WORKWEEK AND OFFICIAL DUTY

a. Unless otherwise indicated, the "basic workweek" for full-time employees shall be 40 hours in length. The normal tour of duty within the 40-hour basic workweek shall consist of five 8-hour days, exclusive of the meal period. Directors of field facilities, or their designees, are authorized to fix the hours of duty constituting the normal tours of duty within the 40-hour basic workweek. Full-time physicians, dentists, podiatrists, [chiropractors,] and optometrists to whom the provisions of this chapter apply shall be continuously subject to call unless officially excused by proper authority. This requirement as to availability exists 24 hours per day, 7 days per week.

* * *

d. Because of the continuous nature of the services rendered at hospitals, the facility Director, or designee (in no case less than a chief of service), has the authority to prescribe any tour of duty to ensure adequate professional care and treatment to the patient, consistent with these provisions.

VA Handbook 5005, Part III, Chapter 3, "Title 38 Leave Program"

2. POLICY

- a. The proper care and treatment of patients shall be the primary consideration in granting of leave.

The Secretary has also promulgated regulations relating to appointment scheduling and maximum appointment waiting times for veteran patients. These regulations are found in VHA Directive 2002-059, "Priority for Outpatient Medical Services and Inpatient Hospital Care;" VHA Directive 2003-062, "Priority Scheduling for Outpatient Medical Services and Inpatient Hospital Care for Service Connected Veterans;" and VHA Directive 2003-063, "Process For Managing Patients When Patient Demand Exceeds Current Clinical Capacity." The pertinent provisions of these regulations are as follows:

VHA Directive 2002-059:

4. ACTION: Beginning on October 1, 2002, Network and medical center Directors must ensure health care facilities implement the following procedures to manage appointment scheduling:
 - a. All veterans service-connected 50 percent or greater who: (1) have an appointment scheduled greater than 30 days, or (2) are on a wait list for an appointment must be contacted. New patients must be notified of this policy and, if they request, must be scheduled within 30 days. Established patients, if requested upon contact by VA, must have their need for an appointment reviewed to determine what timeline is medically appropriate. A clinic visit will be scheduled or rescheduled, based on the clinicians' review. ...

VHA Directive 2003-062:

4. ACTION: Network and medical center Directors must ensure health care facilities implement the following procedures to manage appointment scheduling for new enrollees and established patients who require care for a SC disability. ...
 - a. All new enrollees and/or new patients who are rated less than 50 percent SC requiring care for a SC disability, and who request VA care, must be scheduled for a primary care evaluation within 30 days of desired date. ...
 - b. Appointments for established patients (i.e., a patient who has received care anywhere in the VA system within the past 2 years) who are less than 50 percent SC requiring the appointment for a SC disability, must be scheduled within 30 days of the clinically appropriate appointment date based on the clinical need of the veteran as determined by the veteran's VA treating clinician. ...

VHA Directive 2003-068:

4. ACTIONS

* * *

b. Facility Director. Each facility Director is responsible for ensuring that:

* * *

(2) All Patients are Scheduled for Care Using the Following Business Rules.

(a) Urgent or Emergent Care. Patients with emergent or urgent medical needs must be provided care or be scheduled to receive care as soon as practicable. ...

(b) Priority Scheduling for Outpatient Medical Services and Inpatient Care for SC Veterans. ...

1. All new enrollees and/or new patients who are 50 percent or greater SC veterans, or veterans less than 50 percent SC requiring care for a SC disability who request VA care, must be scheduled for a primary care evaluation within 30 days of desired date. ...

2. Appointments for established patients (i.e., a patient who has received care anywhere in the VA system within the past 2 years) who are 50 percent or greater SC, or less than 50 percent requiring the appointment for a SC disability, must be scheduled within 30 days of the clinically appropriate appointment date based on the clinical need of the veteran as determined by the veteran's VA treating clinician. ...

PROCEDURAL HISTORY

The Secretary has delegated to the USH the authority to determine whether a matter or question concerns or arises out of professional conduct or competence (direct patient care, clinical competence), peer review, or employee compensation within the meaning of 38 U.S.C. 7422(b).

ISSUE

1. Whether the May 10, 2004 grievance over management's scheduling of patients during time set aside for CME or administrative time involves an issue of professional conduct or competence (direct patient care) within the meaning of 38 U.S.C. 7422(b).
2. Whether the provisions of the parties' May 10, 2001 MOU involve issues of professional conduct or competence (direct patient care) within the meaning of 38 U.S.C. 7422 (b).

DISCUSSION

As outlined above, the subject grievance alleges that management violated both a past practice and the provisions of the parties' May 10, 2001 MOU in rescheduling patients during times usually reserved for CME or administrative time. In essence, the grievance asserts that VA NIHCS was bound by collective bargaining to prioritize physicians'

previously scheduled administrative and training activities over patient care needs. Both the grievance and the labor-management arrangements alleged to support it clearly involve issues of direct patient care and, as such, fall within the bargaining exclusion for professional conduct or competence under 38 U.S.C. § 7422(b).

What is more, the parties' MOU, by its terms, places specific non-negotiable limits on physicians' availability for patient care. By agreeing to strict limitations on management's right to assign rotations and back-up duty, the number of patients to be seen per day, and the distribution of patients to various providers, the parties negotiated over patient care issues specifically excluded from collective bargaining by 38 USC § 7422(b). The potential for these provisions to interfere with patient care is clear from the subject grievance, wherein the union claimed the MOU forbids scheduling patients during physicians' bargained-for administrative time.

Each and every provision of the MOU has the potential to interfere with patient care or, in the case of an alleged violation, to allow a grievance arbitrator to override VA NIHCS management's clinical patient care decisions.⁵ The impact of each provision is as follows:

Provisions 1 and 6 set strict rules for physicians' backup and rotation duties, thereby requiring management to assign patient care duties based on contract terms rather than patients' needs or providers' clinical skills.

Provision 2 precludes management from scheduling patients during administrative time, irrespective of patient care needs, and also specifically limits the number of patients a physician can be required to see in the morning before an administrative-time afternoon. Provision 3 strictly prohibits overbooking, or scheduling more than one patient per appointment slot, which in turn caps the number of patients a physician can see per day. The first portion of Provision 4 limits each physician's Primary Care Clinic to 11 patients per day, irrespective of the number of patients who need to be seen. Compliance with these provisions would require that patients be waitlisted or turned away when patient demand exceeds providers' bargained-for patient care hours.

The latter portion of Provision 4 requires that new patients be distributed among the clinics on a fair and equitable basis. While equitable distribution of workload may be a desirable goal, this bargained-for requirement precludes management from assigning new patients to providers based on the patients' needs or the providers' clinical competence if doing so might -- in the view of a physician, the union, or an arbitrator -- unfairly burden one provider more than another.

Provision 5 exempts a part-time provider from covering the Hospitalist position even if, for some clinical, patient-driven reason, management determines to assign her such duties. Provision 7 requires that the most recently-hired physician see most of the facility's new patients, even when a particular new patient's needs might be better met by

⁵ It must also be noted that nearly every provision of the MOU impermissibly interferes with management's right to assign work and is therefore non-negotiable under 5 USC § 7106(a)(2)(A) as well as 38 USC § 7422(b).

another physician's clinical skills. Provision 8 requires that the medications renewal and administrative paperwork of physicians on leave be performed by another member of the absent physician's team, irrespective of patient care needs. Each of these provisions directly affects patient care by dictating which providers will and will not be assigned particular patient-care tasks.

Provisions 9 and 10, while benign on their face, require review and/or renegotiation of the MOU without reference to the patient care concerns that render the existing provisions non-negotiable.

For these reasons, the MOU, in its entirety, restricts management's ability to make scheduling and staffing determinations based on patient care needs, and is therefore non-negotiable under 38 U.S.C. 7422(b).

In a prior decision, Wilmington VAMC, (December 4, 2001) also involving matters relating to patient scheduling, staffing, and panel size, the USH has determined that such provisions involve professional conduct or competence (direct patient care) within the meaning of 38 U.S.C. 7422(b).

RECOMMENDED DECISION

1. That the May 10, 2004 grievance over management's scheduling of patients during time set aside for CME or administrative time involves an issue of professional conduct or competence (direct patient care) within the meaning of 38 U.S.C. 7422(b) and is therefore excluded from the negotiated grievance procedure.

APPROVED

DISAPPROVED

2. That the parties' May 10, 2001 MOU involves issues of professional conduct or competence (direct patient care) and is therefore non-negotiable under 38 USC § 7422 (b).

APPROVED

DISAPPROVED


Jonathan B. Perlin, MD, PhD, MSHA, FACP
Acting Under Secretary for Health


Date