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The Voice of VA Physicians and Dentists Since 1975

NEWS

Volume 34, Number 2
September/October, 2012

Extended Pay Freeze Edges Ever Closer

The Good News? On September 7, the House of Representatives approved a $1.047 trillion stopgap spending bill that averts a government shutdown on September 30.

The Bad News? President Obama indicated in an August letter to Congress that he would grant federal employees a 0.5% raise in 2013, but only if/when Congress passes a budget. Since the temporary spending bill will give the government the funds it needs to operate for another six months, if it is passed by the Senate and signed into law, that would mean the federal pay freeze will continue until at least April.

Congress has been reluctant to engage any major legislation or debates until after the November election which would certainly include a budget debate. This reluctance almost assures that a budget deal will not be reached until the last possible moment, if then.

The stopgap spending bill represents a bit of unusual bipartisan action since it contains spending that is $19 billion higher than the budget Paul Ryan wrote.

The stopgap measure permits an across-the-board 0.6% increase to agency budgets in accordance with the budget deal agreed to last summer. It also maintains spending on domestic programs rather than shifting $8 billion from domestic programs to the Pentagon. But no thaw on federal employee pay... ❖

VA Has its Own Wasteful Spending Comeuppance

A few months ago, the news stories were all about the outrageous spending by the GSA, which had spent an incredible $800,000 on a regional conference. Congress went into spasm with hearings almost daily. A few heads rolled at GSA. Other agencies thanked their stars that it was not them on the hot-seat.

Alas, it recently became known that the VA had spent $5 million— and set aside $4 million more—on two conferences at the Marriott World Center in Orlando, Florida in July and August of 2011. These multimillion dollar events were not high-tech conferences to improve the quality of medical care. They weren't even related to patient care (the purported focus of the VA system).

No, these incredibly expensive conferences were for Human Resource employees who put not a finger upon patients, and who in fact often impede attempts to hire caregivers for patient care. About 1800 HR employees attended, so the cost was around $2,800 per employee. Had the set-aside $4 million had been spent, the cost approaches $5,000 per employee. Providence forbid the VA spend $1000 per physician for CME.

So, what did the attendees and the government get for these outrageous expenditures? It is reported that VA spent roughly $84,000 on promotional giveaways including highlighters and pens with the agency's logo. Multiple planning trips cost about $13,000. Not to be outdone by GSA's magicians, clowns and drumming sessions, the VA spent $52,000 for a video send-up of a portion of the movie "Patton."

Further, it is alleged that some of the VA employees scouting hotels and locations for the conferences may have illegally accepted gifts—including free rides in helicopters and a stretch limo—from hotels that were being considered. Gifts to organizers may also have included free lodging, food, alcohol, concert tickets, spa treatments and gift baskets. Congressional hearings are expected. Surprise, surprise! ❖

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Samuel Spagnolo, MD

The President's Corner

The End of a Long, Hot Summer

Minutes ago the US Commerce Department reported the final Q2 yesterday (Q2 is a measure of recent economic growth or the US GDP for the second quarter). It now appears that the US economy grew at only 1.3 percent in the second-quarter of the year, below the previously reported rate of 1.7 percent, according to the Commerce Department's third and final estimate of that period. As I noted in an earlier message federal wages remain frozen, the dollar continues to be weak, interest on savings remains near zero, prices for most consumer goods are still rising, and for most Americans the standard of living is falling. I keep looking for some really good news.

The Congress, having worked so "hard" to fix our fiscal nightmare, is now in recess so all can campaign for reelection, and the President appears to have been missing in action since early this year. The congressional passage of a recent continuing resolution will fund the government at about the same level for the next several months while all await the result of the upcoming national election.

The Affordable Care Act (ACA) commonly referred to as Obama Care is now the law of the Nation and its impact on the future of VA health care remains cloudy.

In a recent article (JAMA, February 22/29, 2012—Vol 307, No. 8) Dr. Kenneth Kizer, former Undersecretary of the VA, stated that the ACA may affect health care for many veterans through its effects on access, fragmentation and quality of care, utilization of services, the health care work force, and federal expenditures. He went on to say that if more veterans have insurance options, then they may seek care outside the VA system and ameliorate some staffing needs; however, past experience has shown that the relationship between health care workforce issues and demand for services in the VA system is difficult to predict. With the government running a trillion dollar deficit any predictions about increased VA funding for the future seem to be wishful thinking. In this regard, NAVAPD has heard various rumors including the need to hire more nurse practitioners and physician assistants as replacement for more costly physicians.

(Continued on page 7)

NAVAPD's Mission and Principles

Mission

NAVAPD is dedicated to the principle that this Nation's Veterans, as a result of their service to our country's Armed Forces, have earned an entitlement to quality health care to meet their needs as they become sick or injured. The Department of Veterans Affairs ("VA") is that agency of government obligated to honor the Nation's contract with its deserved Veterans.

NAVAPD has as its highest priority the preservation and strengthening of the VA Health Care system, so that it stands ever ready to give Veterans quality medical care equal to or better than that which can be obtained elsewhere in our society.

Just as VA doctors care for those who have served, they also stand ready to treat the military and civilian casualties of future conflicts and non-military disasters.

VA Health Care facilities are a principal element in our national security and in our national defense, representing as they do a vast resource to back up the limited capabilities of our military hospitals.

Guiding Principles

NAVAPD shall function as the official professional organization of the VA physicians and dentists at all levels in the VA Health Care system, from the local health care facilities through VISNs to the national level.

NAVAPD shall cooperate to the maximum extent possible with official representatives of the VA, to the end that the best possible health care is provided to Veteran beneficiaries.

NAVAPD shall endeavor to ensure that qualified physicians and dentists are recruited into the VA Health Care system and retained therein.

NAVAPD shall support VA physician research, participate in activities of professional organizations, continuing medical education and participation in equal partnership affiliation with medical schools.

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VHA Directive Requires Timely Notification of Malpractice Action

NAVAPD periodically receives complaints from physicians and dentists that they are not advised of a malpractice action involving them until a settlement has already been reached. Often their only notice is when they are advised that they are being reported to the National Practitioner Data Base (NPDB).

VHA policy stipulates that this is not to occur. In fact, physicians or dentists (actually, any licensed medical professionals) are to be notified within 30 days of Regional Counsel advising the facility Director of such action. VHA policy makes it the facility Director's responsibility to ensure this happens.

The VHA Directive is reprinted here for your reference, just in case you get caught in such a situation. Or in case you want to remind your administration so this does not happen to you. ❖

Department of Veterans Affairs **VHA DIRECTIVE 2009-032**
Veterans Health Administration
Washington, DC 20420 **July 15, 2009**

NOTIFICATION OF MEDICAL MALPRACTICE (TORT) CLAIMS AGAINST LICENSED PRACTITIONERS

1. PURPOSE: This Veterans Health Administration (VHA) Directive describes the duty of Department of Veterans Affairs (VA) medical facility Directors to notify practitioners whose care is the subject of a claim for medical malpractice. ***NOTE****: This Directive does not discuss disclosure of adverse events to patients or their families; that information is found in VHA Directive 2008-002, Disclosure of Adverse Events to Patients.*

2. BACKGROUND: Under the provisions of Public Law 99-660, the Health Care Quality Improvement Act of 1986, which established the National Practitioner Data Bank (NPDB), and a Memorandum of Understanding (MOU) between VA and the Department of Health and Human Services (HHS), VHA must report certain malpractice payments and certain clinical privileges actions to the NPDB and appropriate state licensing boards. VHA's reporting requirements are set forth at Title 38 Code of Federal Regulations (CFR) Part 46, and are applicable to all VHA licensed health care practitioners involved in patient care who are employed, appointed, contracted for, or otherwise utilized under job titles listed in the NPDB document entitled "Occupation/Field of Licensure Codes." These regulations establish a malpractice payment review process, and authorize licensed practitioners to submit a written statement for consideration by the review panel which will determine for whose benefit a claim for medical malpractice was made. However, because the regulations concern only the post-payment review process, some practitioners have asserted that they do not receive timely notice of claims. VHA believes that the notification of licensed practitioners at the time a claim for medical malpractice has been made helps ensure the fairness of the claim resolution process. ***NOTE****: This Directive does not discuss the tort claim post-payment review process or reporting required following an adverse action against a physician or dentist (see VHA Handbook 1100.17).*

3. POLICY: It is VHA policy that each facility Director provide written notification to all licensed practitioners when a claim for medical malpractice is filed with respect to care provided by that practitioner; such notification must be provided within 30 days from the date a Regional Counsel notifies the facility Director that a claim for medical malpractice has been filed under the Federal Tort Claims Act (FTCA), Title 28 United States Code (U.S.C.) 1346(b), 2671-2680.

4. ACTION: Each medical facility Director, or designee, is responsible for ensuring that:

a. Each licensed practitioner is given written notice when a claim for medical malpractice is filed with respect to care provided by the practitioner. The notice forwards the information provided by the Regional Counsel as to:

THIS VHA DIRECTIVE EXPIRES JULY 31, 2014

VHA DIRECTIVE 2009-032
July 15, 2009

(1) Patient's name and address, as provided on the Standard Form (SF) 95, Claim for Damage, Injury, or Death, claim form;

(2) Date(s) the incident giving rise to the claim occurred;

(3) Incident described in the claim;

(4) Asserted basis of malpractice liability; and

(5) Name and telephone number of the Regional Counsel for the facility where the event occurred.

b. A copy of the notice is forwarded to the appropriate Regional Counsel office.

5. REFERENCES

a. Title 42 U.S.C. 11101-11152, The Health Care Quality Improvement Act of 1986.

b. Memorandum of Understanding between the Secretary of Veterans Affairs and the Secretary, Health and Human Services, effective October 1, 1990.

c. Title 38 CFR Part 46, as amended. Policy Regarding Participation in the National Practitioner Data Bank, 67 Federal Register. 19678 (April 23, 2002).

d. VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook.

e. VHA Handbook 1100.17, National Practitioner Data Bank Reports.

f. VHA Directive 2008-002, Disclosure of Adverse Events to Patients.

6. FOLLOW-UP RESPONSIBILITY: The Office of Patient Care Services (11) is responsible for the contents of this Directive. Questions may be addressed to the Director, Office of Medical-Legal Affairs (11ML) at 716-862-8521.

7. RECISSIONS: VHA Directive 2004-024, dated June 10, 2004, is rescinded. This VHA Directive expires July 31, 2013.

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

DISTRIBUTION: E-mailed to the VHA Publication Distribution List 7/17/09

An All-in-One Place to Check TSP Fund Returns

Would you like a simple, single place to check the progress of the funds you are investing in with your TSP? *FedSmith.com* recently announced a new email list to help you stay informed of the daily changes in the TSP share prices.

"The Daily Wrap-Up" is a free email subscription sent at the end of each business day that lists the closing share prices for each of the TSP funds. It also shows the change in value over the previous day, the YTD percentage return for each fund, and the 52 week high/low for each fund.

To sign up for this daily email visit TSPDataCenter.com to sign up for this free service. Just look for the "Free Email Updates" box on the right-hand side of the page.

In future changes to the NAVAPD website, we will include links to this and other online resources

The image below is a sample of what this email looks like:

THE DAILY WRAP-UP

SEPTEMBER 7, 2012

Closing TSP Rates

September 7, 2012

Fund	Last	Change	YTD	52 Week High	52 Week Low
L Income	$15.5951	$0.0224	3.9355%	$15.5951	$15.0412
L 2020	$18.4887	$0.0743	8.6778%	$18.4887	$17.1134
L 2030	$19.1650	$0.0949	10.5433%	$19.1650	$17.4491
L 2040	$19.7433	$0.1117	11.9457%	$19.7433	$17.7452
L 2050	$10.8888	$0.0702	13.1974%	$10.8888	$9.6595
G Fund	$13.9630	$0.0004	1.0399%	$13.9630	$13.8213
F Fund	$15.9101	$0.0122	3.6381%	$15.9576	$15.3046
C Fund	$18.0449	$0.0738	16.1946%	$18.0449	$15.7708
S Fund	$23.8604	$0.1389	16.2448%	$23.8604	$20.7100
I Fund	$19.4740	$0.2600	10.3599%	$19.9249	$16.6512

NPs Should Not Lead Medical Homes, AAFP Says

From Medscape Medical News

Nurse practitioners (NPs) should not supplant physicians as leaders of patient-centered medical homes because their training does not qualify them for that post, according to a report issued recently by the American Academy of Family Physicians (AAFP). In addition, the AAFP report warned that independent NPs should not be substituted on a wholesale basis for primary care physicians, even though the latter are in short supply.

"Granting independent practice to NPs would be creating 2 classes of care, one with physician-led teams and one guided by less-qualified health professionals," Roland Goertz, MD, chair of the AAFP board of directors, said at a press conference yesterday. "Americans should not be forced into this 2-tiered scenario. Everyone deserves to be under the care of a physician."

The medical home is a team-based approach to healthcare touted by reformers for its potential to improve quality while lowering costs. The goal is to provide easily accessed care that is comprehensive, continuous, and coordinated. Private insurers, Medicare, and Medicaid are experimenting with the medical home, and the Affordable Care Act promotes the concept as well.

The report released yesterday said that although NPs are valuable members of the medical home team, they are not qualified to head the household. It notes that family physicians receive 11 years of college and graduate-level education, including residencies, compared with from 5.5 to 7 years of schooling for NPs.

A press release issued by the AAFP quotes the leaders of the American Academy of Pediatrics (AAP), the American Medical Association, and the American Osteopathic Association (AOA) as concurring with the report's conclusions.

This is not the first time that organized

(Continued on page 7)

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America's Most Dangerous Jobs

As VA employees know, there are plenty of things to stress and upset VA employees. Fortunately, our irritants are rarely life-threatening, and fall nowhere near the top of the dangerous jobs list.

Every year, the Bureau of Labor Statistics releases data on workplace fatalities, including industries with the highest fatality rates. While some sectors that made the list aren't surprising due to the nature of the work -- transportation and mining, for example -- others, such as professional and business services, may be more unexpected.

According to the most recent report, 4,609 fatal work injuries were recorded in the U.S. in 2011. While it's difficult to find good news in this type of report, this preliminary number was down from 4,690 in 2010.

Industries known for high fatality rates also saw a downward trend in year-over-year deaths. The number of fatal work injuries in the private construction sector declined by 7 percent in 2011. Economic conditions, which caused the delay or termination of construction projects, may explain some of this decline. Fatal coal mining injuries also declined sharply, from 43 in 2010 to 17 in 2011; the 2010 number reflected a spike caused by the Upper Big Branch Mine disaster. However, fatal work injuries in the professional and business services sector, a less obvious group that includes marketing, human resources and payroll services, were up 16 percent.

So as you ponder all of the bad things you face daily, be happy that you are not among these businesses.

Ten sectors with the highest fatal work injury rates (per 100,000 full-time workers):

1. Agriculture, forestry, fishing and hunting
Fatal work injury rate: 24.4
Number of fatal work injuries: 557

2. Mining
Fatal work injury rate: 15.8
Number of fatal work injuries: 154

3. Transportation and warehousing
Fatal work injury rate: 15.0
Number of fatal work injuries: 733

4. Construction
Fatal work injury rate: 8.9
Number of fatal work injuries: 721

5. Wholesale trade
Fatal work injury rate: 4.9
Number of fatal work injuries: 189

6. Utilities
Fatal work injury rate: 4.2
Number of fatal work injuries: 39

7. Professional and business services
Fatal work injury rate: 2.9
Number of fatal work injuries: 424

8. Other services (e.g., equipment and machinery repairing, promoting or administering religious activities, grant-making)
Fatal work injury rate: 2.9
Number of fatal work injuries: 177

9. Government
Fatal work injury rate: 2.2
Number of fatal work injuries: 495

10. Manufacturing
Fatal work injury rate: 2.2
Number of fatal work injuries: 322

Ten occupations with high fatal work injury rates (per 100,000 full-time workers):

1. Fishers and related fishing workers
Fatal work injury rate: 121.2

2. Loggers
Fatal work injury rate: 102.4

3. Aircraft pilots and flight engineers
Fatal work injury rate: 57.0

4. Refuse and recyclable material collectors
Fatal work injury rate: 41.2

5. Roofers
Fatal work injury rate: 31.8

6. Structural iron and steel workers
Fatal work injury rate: 26.9

7. Farmers, ranchers and other agricultural managers
Fatal work injury rate: 25.3

8. Driver/sales workers and truck drivers
Fatal work injury rate: 24.0

9. Electrical power-line installers and repairers
Fatal work injury rate: 20.3

10. Taxi drivers and chauffeurs
Fatal work injury rate: 19.7

The report also includes information on the causes of these workplace fatalities. Topping the list is transportation incidents, which accounted for more than two out of every five fatal work injuries. Also high on the list? Workplace violence, with 458 homicides and 242 suicides recorded in 2011.

Fatal occupational injuries by major event:

- Transportation incidents – 41 percent
- Violence and other injuries by people or animals -- 17 percent
- Contact with objects and equipment – 15 percent
- Falls, slips and trips -- 14 percent
- Exposure to harmful substances and environments -- 9 percent
- Fires and explosions -- 3 percent

In a statement responding to the report, Labor Secretary Hilda L. Solis said, "It's clear that we must maintain our commitment to ensuring our workplaces are safer and healthier for every American. This is a challenge that must be undertaken not just by the government but by the entire country. We know how to prevent these fatalities, and all employers must take the steps necessary to keep their workers safe." ❖

NPs Should Not Lead Medical Homes, AAFP Says (continued)

(Continued from page 5)

medicine has taken a stand against NPs taking the helm of the medical home. In March 2011, the AAFP, the AOA, the AAP, and the American College of Physicians released model guidelines for accrediting medical homes that would prohibit NPs from being in charge. Of 4 organizations that accredit medical homes, only the Accreditation Association for Ambulatory Health Care limits the top spot to physicians.

The controversy over medical home leadership dovetails with the controversy over independent practice for NPs. According to the AAFP report, 22 states and Washington, DC, allow NPs to diagnose and treat disease on their own, although roughly half of them require that a physician supervise prescriptions. The AAFP opposes widening scope-of-practice regulations on NPs, arguing that these clinicians must not work apart from physician oversight.

"I Didn't Know What I Didn't Know"

The AAFP press conference featured an NP and an NP turned family physician, both of whom attempted to buttress the academy's report.

The NP, Julie Deters, works in a medical home directed by family physician John Bender, MD, in Fort Collins, Colorado. Deters described how content she was with her role. "I feel like I have the best role in the best place in medicine," Deters said. "Dr. Bender and I work collaboratively on a daily basis. We have a very trusting relationship." She said Dr. Bender is available 24/7 for consultation, "when things don't quite add up."

LaDona Schmidt, MD, a former NP who practices in Salina, Kansas, discussed how her MD training surpassed her NP training. "Forgive me for saying this, but I figured [medical school] would be a breeze because I was so close to being a doctor," said Dr. Schmidt. "The truth was I didn't know what I didn't know until I went [through] 7 more years of education."

Although NP training introduced her to anatomy, she spent 5 days in her medical school anatomy class just studying facial muscles. Pharmacology education escalated from the broad function of a particular drug to how the stomach absorbs it and how the kidney excretes it. "All these light bulbs were going off," she said. Similar to Dr. Goertz, Dr. Schmidt called NPs important members of the healthcare team, but said that "perceived shortages in [primary care physicians] don't justify less-than-qualified care for our families."

NP Leader Says Profession Can Coordinate Care

NPs who favor independent practice for their profession have heard all these arguments before, said Marsha Siegel, EdD, an NP in Cheyenne, Wyoming, and a past president of the American College of Nurse Practitioners.

Dr. Siegel told *Medscape Medical News* that a primary care NP is not a "full substitute" for a primary care physician, but nevertheless is qualified to direct a medical home. That role emphasizes coordinating care, which an NP can do, whether the patient needs a hand-off to a primary care physician or a specialist. That is already happening in NP-owned practices that employ physicians, she said.

She contested the argument that patient care slips when an NP supplies it. Studies going back to 1996, she said, document that "we have been providing quality of care equal to or better than that of primary care physicians."

Another point to clarify, she said, is the educational differences between NPs and physicians, which reflect 2 different professional outlooks. "NP education...is more holistic," she said. "Medical training is primarily disease-focused." Dr. Siegel added that although physician education is longer, the undergraduate years can be spent as an English or history major. Nurses, in contrast, focus on nursing as undergrads.

Dr. Siegel said she does not think the AAFP report will sour the relationship of NPs and physicians in medical practices across the country. Although the 2 professions are battling each other on an organizational level over the medical home, said Dr. Siegel, "out in the field, we get along with each other very well. "We respect each other's roles." ❖

Help NAVAPD Help You. Encourage your peers to join NAVAPD.
When we approach politicians, the larger our membership, the better they listen.

The President's Corner (continued)

(Continued from page 2)

What will happen after the upcoming election is currently anybody's guess but for sure various special interest groups will be knocking at Congressional doors to decide your professional future.

NAVAPD will make a point of being one of those groups trying to positively impact any decisions made in this regard. Collaborating with other groups will be crucial to ensure the success of such an endeavor. We will keep you updated via the web site (www.navapd.org) and our other communications tools. ❖

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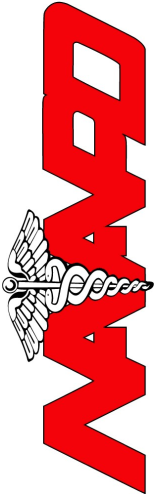

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