Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Access and Coordination of Care at Harlingen Community Based Outpatient Clinic
VA Texas Valley Coastal Bend Health Care System
Harlingen, Texas

Report No. 12-01906-259

August 22, 2012

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of allegations made by a complainant related to access and coordination of care issues at the VA Texas Valley Coastal Bend Health Care System (HCS) in Harlingen, Texas (facility) and the Community Based Outpatient Clinic (CBOC) in Harlingen, Texas. The complainant alleged that:

- Patients are presenting to the CBOC for urgent and emergent medical care that is not available, losing possibly life-saving minutes while waiting to be triaged and transferred to the appropriate level of care.
- Patients cannot be seen in the timeframe requested by the patient or provider resulting in delays in follow-up care and in getting medications as well as long wait times in the CBOC.
- Providers were pressured into prescribing pain medications to drug-seeking patients.

We substantiated that patients go to the CBOC for urgent and emergent medical care; cannot be seen in the timeframe requested by the patient or their provider; have difficulty getting medications filled, refilled, or renewed; and that patients experience long wait times at the CBOC.

We did not substantiate that providers were pressured into prescribing pain medications to drug-seeking patients.

We recommended that the Facility Director:

- Ensure that patients receive increased education on the process for seeking emergent care in the community.
- Ensure that local transfer policies and community hospital contracts are reviewed for congruency.
- Ensure that primary care panel sizes are reviewed and maintained according to VHA directives.
- Ensure that all current CBOC staffing levels and patient flow plans are reviewed and adjusted to ensure consistency with local policy.

The Veterans Integrated Service Network and Facility Directors agreed with our findings and recommendations and provided acceptable improvement plans.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA Heart of Texas Health Care Network (10N17)

SUBJECT: Healthcare Inspection – Access and Coordination of Care at Harlingen Community Based Outpatient Clinic, VA Texas Valley Coastal Bend Health Care System, Harlingen, Texas

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to determine the validity of allegations made by a complainant related to access and coordination of care at the Harlingen Community Based Outpatient Clinic (CBOC) in Harlingen, TX.

Background

The CBOC is part of the VA Texas Valley Coastal Bend Health Care System (HCS) in Harlingen, TX. The CBOC provides outpatient health care including primary care, mental health, nutrition, social work, laboratory, and pharmacy services. The CBOC is located less than 1 mile from the parent facility, the VA Health Care Center at Harlingen (facility). Veterans Health Administration (VHA) established the HCS October 1, 2010, to serve veterans in 20 counties in South Texas. The facility provides inpatient care and emergent care through contracts with local community hospitals and uses fee-basis[1] referrals for specialty care not available through the facility.

A complainant used OIG's Combined Assessment Program's Employee Assessment Review Survey to provide the OIG with allegations involving access and coordination of care at the CBOC. Specifically, the complainant alleged that:

- Patients are presenting to the CBOC for urgent and emergent medical care that is not available, losing possibly life-saving minutes while waiting to be triaged and transferred to the appropriate level of care.

[1] Purchased or fee-basis care is used when VA services are unavailable or cannot be provided due to geographic inaccessibility.

- Patients cannot be seen in the timeframe requested by the patient or provider resulting in delays in follow-up care and in getting medications as well as long wait times in the CBOC.
- Providers were pressured into prescribing pain medications to drug-seeking patients.

As the allegations encompassed concerns related to several CBOC services and policies including access to emergency care, primary care Patient Aligned Care Team (PACT) panel size, seasonal veterans, Pharmacy Service, and Pain management, a brief overview of these services follows.

The CBOC does not provide emergency medical care onsite. These services are provided through a contract agreement with a local hospital Emergency Room (ER). Patients are advised to call 911 or go directly to the closest contracted ER for emergent care.[2] Local policies define procedures for transferring patients for urgent and emergent medical issues from the CBOC.[3,4]

The CBOC delivers its primary care services through VA's PACT model.[5] Local policy describes the PACT model including core team membership.[6] The PACT core members are the patient, a primary care provider, a registered nurse (RN) care coordinator, a clinical staff assistant, and an administrative staff member. Coordination of care services is the responsibility of the RN care coordinator and a case manager (CM). The RN care coordinator, clinical staff assistant, and administrative staff member serve the provider's entire panel of patients.

During the enrollment process, each CBOC patient is assigned to a specific provider, and becomes a member of that provider's panel of patients. The local facility determines the maximum panel size for their primary care providers. The VHA-modeled panel size is 1,200 patients for a full time physician.[7]

Due to its geographic location, the CBOC serves a number of veterans traveling away from their primary residence that need non-routine medical care ("seasonal veterans"). VHA recommends that seasonal veterans needing acute care present to the local facility and see the referral CM. The CM will coordinate patients' acute care needs, but the

[2] Harlingen VA Outpatient Clinic Intranet website, http://vaww3.va.gov/directory/guide/facility.asp, accessed on May 15, 2012.
[3] VA Texas Valley Coastal Bend Health Care System Policy Memorandum 11C-11-08, *Triage of Walk-In Patients*, February 23, 2011.
[4] VA Texas Valley Coastal Bend Health Care System Policy Memorandum 11-10-06, *Walk-In and Late Patient Policy*, December 2, 2010.
[5] Primary Care Program Office: Patient Aligned Care Team website, http://www.va.gov/primarycare/pcmh/, accessed on May 15, 2012.
[6] VA Texas Valley Coastal Bend Health Care System Policy Memorandum 11-11-83, *PACT Policy*, March 25, 2011.
[7] VHA Handbook 1101.02, *Primary Care Management Module (PCMM)*, April 21, 2009.

patient is typically not assigned a provider at the visiting facility. Patients are advised to delay routine, non-acute care until they return to the facility near their primary residence. VHA recommends that seasonal veterans be assigned to providers in two locations only if the patient has specialized or complicated medical needs and splits time between two primary residences in different areas of the country; however, this practice should be minimized.[8]

The CBOC pharmacy is able to fill all routine and available VA-approved medications the same day they receive the prescription. VA pharmacists are required to follow VA policy on filling prescriptions and dispensing medications whether a VA, fee-basis, or community provider writes the prescription. Patients may also bring prescriptions written upon discharge from a local hospital to the CBOC pharmacy to be filled. Non-formulary prescriptions are dispensed according to facility policy.[9,10]

VHA defines a process that allows pharmacists to provide a temporary, or "bridge," supply of medications to patients to ensure availability of needed medications until the patient can receive a refill prescription from the patient's usual source.[11] The facility also has a local policy defining the process for providing bridge supplies of medications.[12]

The facility's pain management policy states that all patients have a right to timely and effective pain management.[13] The screening and assessment of pain is the responsibility of the medical staff, but accurate reporting and description of pain is the responsibility of the patient. Local policy recommends patients who display drug-seeking behavior be referred to the Drug Seeking Behavior Committee.

Scope and Methodology

We interviewed the complainant by telephone prior to our site visit. We conducted an onsite visit April 16–18, 2012, and interviewed CBOC patient care staff, scheduling staff, clinic-based outpatient pharmacists, and CBOC leadership. We reviewed documents, data, and policies and performed an electronic health record review of a random sample of patients transferred from the CBOC to a contracted, community hospital ER between March 1, 2011, and February 29, 2012.

[8] VHA Directive 2007-016, *Coordinated Care Policy for Traveling Veterans*, May 9, 2007.
[9] The VA formulary is an approved list of medications used to guide the management of drug therapies.
[10] VA Texas Valley Coastal Bend Health Care System Policy Memorandum 119-10-02, *Outpatient Pharmacy Policy and Procedures*, April 15, 2010.
[11] VHA Directive 2007-016.
[12] VA Texas Valley Coastal Bend Health Care System Policy Memorandum 119-10-16, *Ambulatory Care Medication Policy*, April 9, 2010.
[13] VA Texas Valley Coastal Bend Health Care System Policy Memorandum 11-10-22, *Pain Management*, November 26, 2010.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Issue 1: Urgent and Emergent Care for Patients

We substantiated that patients are presenting to the CBOC for urgent and emergent medical care that is not available at the CBOC and wait to be triaged and transferred to the appropriate level of care.

The CBOC transferred 316 patients to the local contracted hospital ER for care during the review period for an average of 1.26 patients per CBOC day. Our review of a random sample of 32 of these patients found that all 32 had medical issues that justified transfer to the ER. Furthermore, we found that only six (19 percent) of the reviewed patients had a scheduled appointment on the day of transfer; the remaining were patients who walked in for care that day.

We found conflicting facility guidance regarding transferring patients for urgent and emergent care. The contract with the local hospital ER states VA-eligible patients can present to the ER with a medical emergency and receive care. However, if a CBOC provider transfers a patient to the ER, the process for emergency services is as follows:

- The CBOC provider informs the ER provider and VA Utilization Management Clinician of the need for emergent care.
- The VA Utilization Management Clinician authorizes patient treatment, and the CBOC provider informs the ER.
- Copies of medical records and a completed patient transfer form are sent with the patient to the ER.
- VA is responsible for coordinating transportation of the patient to the ER.

Furthermore, two local policies and the local community hospital ER contract all provide conflicting guidance on the process to transfer patients needing emergency care. One local policy instructs staff to call 911 to transfer patients with emergent issues to the ER and patients with urgent issues be seen in the CBOC within 2 hours. The second local policy instructs staff to refer patients with urgent issues to the nearest ER within 2 hours. Staff reported that although the CBOC can transfer most patients to the ER within 60 minutes after check-in and triage, the check-in process and triage time might vary greatly depending upon how many patients are in the CBOC.

Staff relayed several reasons patients gave for continuing to present to the CBOC for urgent and emergent care despite receiving written and verbal instructions to go to the local ER for this type of care. Staff described that some patients preferred to be seen by a CBOC provider before being transferred to the ER. Other patients believed that without a referral to the ER by their VA provider they would be responsible for incurred charges at the non-VA facility. CBOC staff felt these concerns stemmed from previous complaints by community providers who had not received payment for fee-basis services. The facility leadership reported difficulty with coordinating payments for non-VA care while transitioning to an independent VA HCS in 2010. Facility leadership continues to address and resolve payment issues.

Issue 2: Access to Care

Delay in Follow-Up Care

We substantiated that patients cannot be seen in the timeframe requested by the patient or provider.

The CBOC has established five PACTs consisting of a physician, RN, licensed vocational nurse, and a clerk. In addition, a contract physician was hired to treat walk-in patients, but this physician is often temporarily reassigned to work at other CBOCs due to staffing shortages. The contract physician has a small panel of patients assigned as well, but those patients have no other PACT members assigned. Therefore, these PACT patients do not have the same resources as the other PACT patients.

The CBOC has one PACT RN position currently vacant. The remaining four RNs share triage duties for patients who do not have an assigned RN, including the contracted physicians' patients. The RNs triage all walk-in patients assigned to their PACT and patients who do not have a PACT RN. A telephone triage RN at the CBOC answers patient phone calls throughout the day, and this RN helps triage walk-in patients when there is a high patient volume in the CBOC. The PACT RNs are also responsible for any case management duties for their respective team because there are no PACT CMs for the CBOC. Facility leadership acknowledged that one RN CM was needed for every two PACTs; however, there are no immediate plans to establish these positions.

The clerks for the five PACTs rotate on a monthly basis between telephone duties in a telephone room and sitting at the front desk in the CBOC; however, they were not assigned exclusively to one PACT. The clerks had multiple competing duties including clerical support for audiology, dental, diabetic retinopathy, Coumadin®, radiology, and social work clinics in addition to checking in patients for the benefits counselor, covering for the release of information clerk, and serving as the travel clerk. When assigned to telephone duties, the clerk takes calls for all teams and can schedule appointments for various teams and clinics as well as forwarding calls to the appropriate services and PACT for further assistance. Clerks at the front desk check in patients for scheduled

appointments with all CBOC PACT teams, clinics, and services; make future appointments for patients who present requesting appointments; check in walk-in patients; and provide eligible patients with travel vouchers.

All CBOC staff interviewed told us that large provider panel sizes contribute to delays in care. The table below shows that panel sizes for all providers were higher than the facility-determined maximum size.

Active Panel Sizes and limits reported by the facility as of April 02, 2012.

Primary Care Team	Active Panel Size	Maximum Panel Size
Blue	1112	821
Green	1486	1271
Purple	1422	1229
Red	1527	1193
Yellow*	1368	1109
*Yellow (including resident physician panels)	1516	1313

During our interviews, staff reported only one PACT had immediate access for clinic appointments, and this availability had only recently occurred. Another PACT had appointments available in 30 days. The remaining 3 PACTs were booked several months into the future. The PACTs share the burden of seeing the contracted physicians' patients on days when this physician is assigned to another CBOC as well as seeing any walk-in patients during the day. Although the PACT schedule has limited appointments for walk-in patients daily, the need far exceeds the availability.

Staff also reported that seasonal veterans represent a large portion of the walk-in patients each year from October to April, but the CBOC did not have an accurate system for tracking the number of seasonal veterans seen. Staff were unable to identify the referral CM who should be coordinating care for these seasonal veterans even though facility leadership told us the CBOC had a referral CM.

Facility leadership reported that the CBOC requested another PACT based on panel sizes and patient volume, but this is still in the approval process. The facility leadership reported the need to evaluate panel sizes before considering approval for an additional PACT.

Medication Delays

We substantiated that patients have difficulty getting their medications filled, refilled, or renewed.

The CBOC pharmacy has a policy that allows pharmacists, at their discretion, to fill a bridge supply of medication if the patient has a future primary care appointment scheduled. Patients without an appointment are referred to the PACT clerk to make a future appointment or be seen as a walk-in patient for a prescription renewal, depending on patient preference.

The non-formulary medications prescription process causes delays in patients receiving needed medications. Community fee-basis providers are encouraged to prescribe only VA formulary drugs, but if the CBOC receives a non-formulary medication prescription, the pharmacist must contact the community provider to offer formulary alternatives, which can be filled immediately. If the provider feels the non-formulary medication is necessary, the pharmacist sends the request through the PACT RN for provider concurrence prior to submitting a non-formulary medication request. Typical response time through pharmacy service for a non-formulary medication request is 3–5 days with no guarantee of approval. Alternatively, the patient can take the prescription to a community pharmacy for immediate filling at the patient's expense. When asked, the facility could not determine how many fee-basis referrals originated from the CBOC during the review period.

Long Wait Times

We substantiated that patients experience long wait times at the CBOC.

We observed lines of 5–10 patients at various times during the day with only two clerks at the front desk checking in patients. Staff stated the lines were due to the number of walk-in patients rather than patients checking in for scheduled appointments. Staff reported that the CBOC sees approximately 40 walk-in patients on a typical day, but this increases to 65 per day and as many as 100 per day from October through April when seasonal veterans are in the area.

We reviewed CBOC patient complaints during the review period and found complaints concerning wait times and reaching PACTs by telephone. Staff informed us that many patients who cannot reach staff by telephone would come in to be seen as a walk-in patient when the issue could have been addressed over the telephone. Staff identified prescription issues as one of the main reasons for high numbers of walk-in patients. The pharmacy bridge policy is helping to improve this process, but the policy does not cover all of the walk-in patients' pharmacy needs.

Staff also described requests from seasonal veterans for non-acute medical care. Staff informed these patients that according to VA policy, routine care should be provided at the patients' primary VA facility. However, if patients persist in their request to have the service provided while they are in the Harlingen area, staff told us they were directed to enroll patients at the CBOC, assign a provider, and schedule patients' walk-in or future appointments, which causes increased demands on already large panel sizes.

Staff also described how wait times are affected by patient transfers to the local ER. The process is time consuming and can take 30–120 minutes depending upon the patient's medical needs. PACT members must stop routine duties to provide urgent and emergent patient care, thereby increasing wait times for patients with scheduled appointments.

Issue 3: Prescription Pain Medications

We did not substantiate that providers were pressured into prescribing pain medications to drug-seeking patients.

The CBOC providers did not feel pressured to prescribe pain medications inappropriately. Providers told us that they use pain treatment agreements for their patients on chronic pain medications and send consults to the Drug Seeking Behavior Committee when appropriate.

Conclusions

We substantiated that patients present to the CBOC for urgent and emergent medical issues. The reasons patients do not go directly to the ER are numerous. Additional process evaluation is needed to identify ways to encourage patients to seek appropriate care at local contracted hospital ERs rather than presenting to the CBOC where emergency treatment is not available. Furthermore, there is a need for congruency between local policies and the facility contract related to patient transfers for emergency care.

We substantiated that patients have difficulty accessing care with their assigned providers. Most providers did not have available appointments for several months, thus making it impossible for patients to be seen for an acute need without presenting as a walk-in patient. Although PACT schedules have allotted time for walk-in patients each day, the number of walk-in and urgent patients far exceeds the allotted daily walk-in appointment slots.

All core member positions within the PACT need to be filled in order to provide medical care based on the principles of the PACT model of patient care. Clerical staff need to be dedicated to their assigned PACT in order to efficiently and effectively perform the required duties within that PACT. Additionally, a referral CM should be the contact person for seasonal veterans who walk in for care; however, we were unable to determine who the referral CBOC CM was during our site visit.

Panel sizes reported by staff and provided by the facility are larger than facility-determined maximums. The facility has the responsibility to adjust panel sizes based on patient demographics, clinic and staff resources available, as well as any non-primary care duties performed by the provider in order to assign a capacity appropriate to the individual provider. Panel sizes that are larger than expected

maximums may reduce productivity, produce delays in access to care, and can negatively affect the quality of care provided.

The pharmacy medication bridging policy will help decrease the numbers of patients presenting to the CBOC. However, it does not address the reason for the high number of patients requiring temporary refills. The facility needs to address the underlining reasons patients are unable to get appointments in the timeframe requested by their providers before their prescriptions run out or expire and make provisions for seasonal veterans to refill or renew their prescriptions.

During our review, we identified issues such as the high number of walk-in patients, seasonal veterans, telephone communication, and daily emergent medical issues resulting in an average of 1.26 patients per day transferred to the local contracted hospital ER and affecting patient wait times in the CBOC. An in-depth review of patient wait times should be performed to determine ways to decrease wait time and increase patient and staff satisfaction.

We did not substantiate that providers were pressured into prescribing pain medications to drug-seeking patients. The local pain policy addresses appropriate VA-approved practices for treating patients with chronic pain or suspected drug seeking behavior. Providers at the CBOC were aware of the policy and used it properly.

Recommendations

Recommendation 1. We recommended that the Facility Director ensure that patients receive increased education on the process for seeking emergent care in the community.

Recommendation 2. We recommended that the Facility Director ensure that local transfer policies and community hospital contracts are reviewed for congruency.

Recommendation 3. We recommended that the Facility Director ensure that primary care panel sizes are reviewed and maintained according to VHA directives.

Recommendation 4. We recommended that the Facility Director ensure that all current CBOC staffing levels and patient flow plans are reviewed and adjusted to ensure consistency with local policy.

Comments

The Veterans Integrated Service Network (VISN) and Facility Directors concurred with our findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 11–14, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 2, 2012

From: Director, VA Heart of Texas Health Care Network (10N17)

Subject: **Healthcare Inspection – Access and Coordination of Care at Harlingen Community Based Outpatient Clinic, VA Texas Valley Coastal Bend HCS, Harlingen, Texas**

To: Director, Dallas Office of Healthcare Inspections (54DA)

Thru: Director, VHA Management Review Service (VHA 10AR MRS)

1. Thank you for allowing me to respond to this Healthcare Inspection regarding Access and Coordination of Care at Harlingen Community Based Outpatient Clinic, VA Texas Valley Coastal Bend HCS, Harlingen, TX.

2. I concur with the recommendations and have ensured that an action plan has been developed.

3. If you have further questions regarding this inspection, please contact Judy Finley, Quality Management Officer at 817-385-3761, or Denise B. Elliott, VISN 17 HSS at 817-385-3734.

Lawrence A. Biro
Director, VA Heart of Texas Health Care Network (10N17)

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 1, 2012

From: Director, VA Texas Valley Coastal Bend HCS (740/00)

Subject: **Healthcare Inspection – Access and Coordination of Care at Harlingen Community Based Outpatient Clinic, VA Texas Valley Coastal Bend HCS, Harlingen, Texas**

To: Lawrence Biro, Director, VA Heart of Texas Health Care Network (10N17)

1. I concur with the findings noted in this report. Action plans have been developed and monitoring will be conducted on a regular basis.

2. Should you require additional information, please contact Cathy Mezmar, Chief, Quality Management, 956.430.9343.

8/2/12

(original signed by:)
Robert M. Walton
Director, VA Texas Valley Coastal Bend HCS (740/00)

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommended that the Facility Director ensure that patients receive increased education on the process for seeking emergent care in the community.

Concur **Target Completion Date:** August 31, 2012

Facility's Response:

A handout, describing when and how to seek emergent care in the community, was developed and disseminated to all clinical staff. Nursing staff will give the handout to the patients during their PACT visit. The handout will also be available in the waiting rooms and will be presented at New Patient Orientation. Supervisors will certify that all their staff have been educated on the handout and its presentation to patients.

Status: Open

Recommendation 2. We recommended that the Facility Director ensure that local transfer policies and community hospital contracts are reviewed for congruency.

Concur **Target Completion Date:** August 31, 2012

Facility's Response:

The policies related to community contract hospital transfer have been reviewed and rewritten to clarify emergent care. A clinic in-service will be given on the health system transfer process.

Status: Open

Recommendation 3. We recommended that the Facility Director ensure that primary care panel sizes are reviewed and maintained according to VHA directives.

Concur **Target Completion Date:** September 30, 2012

Facility's Response:

A Primary Care Panel Review has been implemented to evaluate the accuracy of current panel sizes. Based on the findings of the Panel Review, panel sizes and staffing needs will be determined per VHA directives. The Associate Chief of Staff for Primary Care will continue to review and maintain primary care panel sizes.

Status: Open

Recommendation 4. We recommended that the Facility Director ensure that all current CBOC staffing levels and patient flow plans are reviewed and adjusted to ensure consistency with local policy.

Concur **Target Completion Date:** September 30, 2012

Facility's Response:

To ensure consistency with local policy and facilitate access, one administrative and one clinical staff member will be designated to assist traveling/seasonal Veterans at each clinic site. Secure messaging, "fix the phones," telephone visits, groups visits, case management for specific patient populations by PharmDs, and Care Coordination Home Telehealth staff will continue to be emphasized for the PACT model of effective resource utilization. Mandatory training will be done with clinic staff to ensure they are aware of these resources.

Status: Open

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Cathleen King, MHA, CRRN, Project Leader Trina Rollins, MS, PA-C, Team Leader Monika Gottlieb, MD, Medical Consultant Misti Kincaid, BS, Management and Program Analyst Lin Clegg, PhD, Biostatistician

Appendix D

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