



DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

April 7, 2015

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-14-3424

Dear Ms. Lerner:

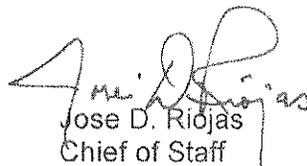
I am responding to your letter regarding allegations made by a whistleblower at the Eugene J. Towbin Healthcare Center, (hereafter, the Medical Center) in North Little Rock, Arkansas. The whistleblower alleged that patients fail to receive timely care from Patient Aligned Care Teams (PACT); that the teams did not treat enough patients to avoid backups; that the PACT telephone system was in disarray; and that management failed to provide proper PACT supervision. The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary as referenced in 5 United States Code § 1213(d)(5).

The Secretary asked that the Interim Under Secretary for Health refer the whistleblower's allegation to the Office of the Medical Inspector, who assembled and led a VA team on a site visit to the Medical Center on December 8-11, 2014. VA deferred the first allegation to the Office of the Inspector General, as they are investigation this allegation. VA did not substantiate the whistleblower's allegation that patients fail to receive timely care from the PACTs or that same-day appointments are rarely used. We did substantiate that backlogs of new patients had existed in the past, and that some patients had been instructed by PACTs to go to the Emergency Department. VA substantiated significant problems with the telephone system and its management but was not able to substantiate that any patients suffered delayed care or were automatically placed on hold because of this.

VA made eight recommendations to the Medical Center, one to Veteran Integrated Service Network 16, and three to VA. I agree with the recommendations and am directing the Medical Center and VA to make the corrections. Investigation findings are contained in the report, which I am submitting for your review.

Thank you for the opportunity to respond.

Sincerely,


Jose D. Riojas
Chief of Staff

Enclosure

**DEPARTMENT OF VETERANS AFFAIRS
Washington, DC**

**Report to the
Office of Special Counsel
OSC File Number DI-14-3424**

**Department of Veterans Affairs
Eugene J. Towbin Healthcare Center,
North Little Rock, Arkansas**



Report Date: March 26, 2015

TRIM 2014-D-1264

Executive Summary

At the request of the Secretary, the Interim Under Secretary for Health (I/USH) directed the Office of the Medical Inspector (OMI) to assemble and lead a team to investigate complaints lodged with the Office of Special Counsel (OSC) by Daniel Wheeler (hereafter, the whistleblower), a Medical Support Assistant (MSA) and employee at the Eugene J. Towbin Healthcare Center, North Little Rock, Arkansas (hereafter, Towbin), part of the Central Arkansas Veterans Healthcare System (hereafter, the Medical Center). The whistleblower alleged that the Medical Center engaged in actions that may constitute a violation of law, rule or regulation, and a specific danger to public health. He described issues regarding mismanagement of the Primary Care (PC) Patient Aligned Care Teams (PACT) and deficiencies in the PACT telephone system. The Department of Veterans Affairs (VA) team conducted a site visit to the Medical Center on December 8–11, 2014, and completed the telephone interviews on January 5, 2015.

Specific Allegations of the Whistleblower

1. Scheduling staff were improperly directed to “zero out” patient wait times, in violation of agency policy;
2. Patients do not receive timely care from PACTs because providers do not treat a sufficient number of patients;
3. Deficiencies in the PACT telephone system create barriers to patient care; and
4. Management's failure to adhere to agency scheduling policies and properly supervise PACTs endangered public health and safety.

VA **substantiated** allegations when the facts and findings supported that the alleged events or actions took place, **did not substantiate** allegations when the facts and findings showed the allegations were unfounded, or **was not able to substantiate allegations** when the available evidence was insufficient to support conclusions with reasonable certainty about whether the alleged event or action had taken place.

After careful review of its investigative findings, VA makes the following conclusions and recommendations:

Allegation # 1

VA defers to the Office of the Inspector General as they are investigating this allegation.

Conclusion for Allegation # 2

- VA **did not substantiate** that patients do not receive timely care from PACTs because providers do not treat a sufficient number of patients.
- VA **substantiated** that, in the past, the PACT had a backlog of new patients waiting to be seen, but currently does not have a backlog.
- VA **did not substantiate** that same-day appointments are rarely used but are used appropriately 70 percent of the time.
- VA found that the same-day appointments slots are used variably by different PACTs, and better management may facilitate the scheduling process.
- VA **substantiated** that patients had been told to go to the Emergency Department (ED); however, this practice was appropriately addressed by management.

Recommendations to the Medical Center:

1. Reevaluate the management of same-day appointments to better utilize available providers to increase access, while ensuring the availability of same day appointments.
2. Continue the efficient management of patients on the New Enrollee Appointment Request (NEAR) list.
3. Continue the ongoing collaborative efforts between the ED and PC and ensure a process for communication.
4. Monitor, track, and trend PC PACT patients that present to the ED with Level V triaged complaints for opportunities for improvement.

Conclusions for Allegation # 3

- VA **substantiated** that the Medical Center has significant problems with the current telephone system and its management. This has resulted in access difficulties, an increase in both patient and staff complaints, and the ED's inability to appropriately refer patients to PACTs.
- VA **was not able to substantiate** that patients' inability to reach their PACTs telephonically resulted in delayed care, as patients would walk-up to the clinic or come to the ED.
- Although VA found evidence that patients were told to go to the ED, in the past, no evidence was found that patients were harmed by being sent to the ED, and VA found no evidence that this is the current practice.

- VA did not find evidence of significant involvement by senior leadership in either the August 2013 or August 2014, telephone programming issues.
- The Executive Assistant (EA) for the Associate Director for Primary Care Services/Nurse Executive (ADPCS/NE) was integral in planning the transfer of MSA telephone calls to the appointment center, as well as attempting to correct the subsequent issues.
- VA found evidence that mid-level staff has been actively working on the telephone issue for at least 2 years.
- VA **was not able to substantiate** that patients were automatically placed on hold for 30 minutes before being cut off.
- VA is concerned that the current Office of Information Technology (OIT) staff does not have the skills and knowledge to correct the telephone problem throughout the Medical Center.
- VA is also concerned that similar telephone issues are not isolated to the Medical Center and may be present elsewhere in the system.

Recommendations to the Medical Center:

5. Train appropriate staff on the management of the phone system.
6. Train the appropriate staff on the reporting capabilities, specifically how to use the available data monitor operator performance, quality, access, and patient satisfaction.
7. Evaluate the functional requirements needed to bring the telephone system online to meet not only the all current monitoring, tracking, and reporting requirements, but to improve communication between both the Medical Center and the Veterans, and other providers with the PACTs.

Recommendations to VA:

8. Conduct a VACO OIT assessment of the Medical Center's communication support and expedite the necessary changes to improve the functionality of the system.
9. Evaluate whether the lack of appropriate equipment and trained personnel to manage the system identified at the Medical Center are systemic to VA, and if so, develop a remediation plan.
10. Conduct an administrative investigation of the role of senior Medical Center leadership in the lack of adequate oversight of the Medical Center's telephone

system's implementation and on-going management issues and take appropriate action.

Conclusions for Allegation # 4

- VA **did not substantiate** that PC leadership failure to properly supervise PACTs endangered public health and safety.
- Current data demonstrated an acceptable level of overall care in primary care; however, hypertension management may be improved.
- VA **substantiated** that upper level management was unaware of the seriousness of the telephone issues, which could potentially cause access issues for patients.
- The ongoing problems with the telephone system caused an increase in patient complaints and dissatisfaction.

Recommendation to the Medical Center:

11. Develop a focus on hypertension management to improve overall blood pressure control.

Recommendation to the Veterans Integrated Service Network (VISN):

12. Review the role of senior leadership in the Medical Center's telephone system management. If there is a lack of knowledge, provide the appropriate training; if a lack of oversight, take the appropriate action.

Summary Statement

VA has developed this report in consultation with other VA and the Veterans Health Administration (VHA) offices to address OSC's concerns that the Medical Center may have violated law, rule or regulation, engaged in gross mismanagement, an abuse of authority, or risked public health or safety. In particular, the Office of General Counsel (OGC) has provided a legal review and the Office of Accountability Review (OAR) has examined the issues from a human resources (HR) perspective, establishing individual accountability, when appropriate, for improper personnel practices. VA did not find that the Medical Center had violated laws, rules or regulations, or posed a specific danger to public health, but that there were past violations of the VHA policies mentioned above.

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I. Introduction

At the request of the Secretary, the I/USH directed OMI to assemble and lead a team to investigate complaints lodged with OSC by the whistleblower, an MSA at Towbin, part of the Medical Center. The whistleblower alleged that the Medical Center engaged in actions that may constitute a violation of law, rule or regulation, and a specific danger to public health. He described issues regarding mismanagement of the PC PACTs and deficiencies in the PACT telephone system. The VA team conducted a site visit to the Medical Center on December 8-11, 2014, and completed the telephone interviews on January 5, 2015.

II. Facility Profile

The Medical Center, part of VISN 16, consists of two hospitals, John L. McClellan Memorial Veterans Hospital in Little Rock and Towbin in North Little Rock. It is a combined tertiary care level 1b facility providing a broad spectrum of inpatient and outpatient health care services, from disease prevention through PC, complex surgical procedures, to extended rehabilitative care.¹ The Medical Center has a total of 255 operating hospital beds and eight community-based outpatient clinics (CBOC) in Conway, El Dorado, Hot Springs, Mena, Mountain Home, Pine Bluff, Russellville, and Searcy, Arkansas; a Home-Based Primary Care Center in Hot Springs; and a Veterans Day Treatment Center for homeless Veterans in downtown Little Rock. Towbin has primary, geriatric, and specialty care outpatient clinics, a 152-bed Community Living Center, 25 transitional residency and 119 domiciliary beds. Together the Medical Center staff provides care and treatment for more than 65,000 Veterans annually. This system serves as a teaching facility for more than 1,500 students and residents enrolled in more than 65 educational affiliate training programs; its principal affiliate is the University of Arkansas for Medical Sciences.

III. Specific Allegations of the Whistleblower investigated by VA

1. Scheduling staff were improperly directed to "zero out" patient wait times, in violation of agency policy. (addressed by the Office of the Inspector General)
2. Patients do not receive timely care from PACTs because providers do not treat a sufficient number of patients.
3. Deficiencies in the PACT telephone system create barriers to patient care.
4. Management's failure to adhere to agency scheduling policies and properly supervise PACTs endangered public health and safety.

¹ **Complexity level 1b:** complexity levels are determined by patient population (volume and complexity of care), complexity of clinical services offered, and education and research (number of residents, affiliated teaching programs, and research dollars). Complexity level 1 is the most complex and level 3 is the least complex; complexity for level 2 facilities is considered moderate. (Veterans' Health Administration Executive Decision Memo (EDM), 2011 Facility Complexity Level Model).

IV. Conduct of Investigation

The VA team consisted of (b)(6) Deputy Medical Inspector, and (b)(6) Clinical Program Manager, from the Office of the Medical Inspector; (b)(6) Chief, Ambulatory Care Nursing, William S. Middleton Memorial VA Hospital & Clinics, Madison, Wisconsin, and (b)(6) HR Specialist from OAR.

The VA team interviewed the whistleblower by phone on December 5, 2014, and per his request, scheduled face-to-face sessions with him on the first and last day of the site visit. Due to personal issues, the whistleblower was unable to participate in those sessions. The team interviewed him a second time by phone, also at his request, on the last day of the site visit. The team reviewed policies, additional reports, memorandums, and other relevant documents listed in Attachment A.

On December 8, we held an entrance briefing at the Medical Center and discussed the Department's whistleblower protection policy with leadership:

- (b)(6) Interim Medical Center Director
- (b)(6) Acting Chief of Staff (COS)
- (b)(6) former Deputy Medical Center Director
- (b)(6) Acting Deputy Medical Center Director
- (b)(6) Associate Director for Patient Care Services (ADPCS)/Nurse Executive (NE)
- (b)(6) Chief, Quality Management (QM)
- (b)(6) Associate COS (ACOS) PC and Emergency Department (ED)
- (b)(6) Deputy ACOS, PC

Immediately after the entrance briefing, the VA team toured both the Medical Center ED, and the Towbin PC and specialty clinics, accompanied by the QM, the ACOS, PC and ED, and the Deputy ACOS, PC.

The team conducted multiple interviews in person or telephonically with:

- The whistleblower
- (b)(6) Interim Medical Center Director
- (b)(6) Acting COS
- (b)(6) former Deputy Medical Center Director
- (b)(6) Associate Medical Center Director
- (b)(6) ADPCS/CNE
- (b)(6) Executive Assistant to the Director
- (b)(6) Administrative Assistant to the COS
- (b)(6), ACOS, PC and ED
- (b)(6) ACOS, Geriatrics

- (b)(6) Medical Director, ED
- (b)(6) Deputy ACOS
- (b)(6) Health Systems Specialist, PCS
- (b)(6) Physician, PC PACT 2
- (b)(6), Physician, Geriatrics PACT 37
- (b)(6) PC PACT 1
- (b)(6) Nurse Manager, PC
- (b)(6) Nurse Manager, ED
- (b)(6) PACT Collaborator
- (b)(6) PC Russellville PACT 1
- (b)(6) Nursing Service
- (b)(6) PC IMPACT, formerly PACT 37
- (b)(6) PC PACT 37
- (b)(6) PC PACT 14
- (b)(6) PC PACT 31
- (b)(6) MSA, Supervisor
- (b)(6) ADPAC, PC
- (b)(6) MSA, Call Center
- (b)(6) MSA, PC PACT 2
- (b)(6) MSA, PC PACT 18
- (b)(6) MSA, PC PACT 37
- (b)(6) MSA, PC PACT 31
- (b)(6) MSA, PC PACT 1
- (b)(6) MSA, PC PACT 30
- (b)(6) MSA, PC PACT 27
- (b)(6) Chief, Office of Information Technology (OIT)
- (b)(6) Deputy Facility CIO, OIT
- (b)(6) Supervisor, OIT

On December 11, 2014, VA held an exit briefing with the Medical Center Leadership including:

- (b)(6) Interim Medical Center Director
- (b)(6), Acting COS
- (b)(6) Acting Deputy Medical Center Director
- (b)(6) Associate Medical Center Director
- (b)(6) ADCS/NE
- (b)(6) Chief, QM

VISN-16 staff, participated by teleconference:

- (b)(6) Acting Chief Medical Officer
- (b)(6) QM Officer

V. Findings, Conclusions, and Recommendations

Allegation # 1

VA defers to the Office of the Inspector General as they are investigating this allegation.

Allegation # 2

Patients do not receive timely care from PACTs because providers do not treat a sufficient number of patients.

2a. Towbin has an excessive backlog of patient PACT appointments; current appointment wait times are two to three months, and during periods of higher demand, appointment delays have reached six months.

Findings

Background

VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook*, establishes the procedures for the administration of PACTs in PC Services.² The PACT is a patient-centered team-based model of care featuring three major principles: patient-centered care, coordination of care, and access to care. The Handbook defines a PACT as a team of health care professionals providing comprehensive care in partnership with the patient (and the patient's personal support person(s)) and managing and coordinating comprehensive health care services consistent with agreed-upon goals. The team is composed of primary care providers (PCP); these are physicians, advanced practice registered nurses (APN) or physician assistants (PA) assisted by RNs, licensed practical/licensed vocational nurses, or health technicians, and clerks serving the health care needs of its panel, the number of patients assigned to the PCP. With its focus on panel management, the PACT's goal is effectively managing its assigned patients rather than tallying the number of patients seen per day. The Handbook defines panel size, panel management, PACT staffing, and the procedures for effectively executing the PACT model. PACTs are further divided into teamlets comprised of staff designated by the Handbook and the Primary Care Management Module (PCMM); each teamlet is assigned a full-time panel of patients receiving comprehensive PC. The recommended

² Primary care is the provision of integrated, accessible health care services by health care professionals accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Primary care includes, but is not limited to: diagnosis and management of acute and chronic biopsychosocial conditions, health promotion, disease prevention, overall care management, post deployment care, and patient and caregiver education. VHA Handbook 1101.10, Patient Aligned Care Team (PACT) Handbook, 4v, page 5.

teamlet staffing ratio is at least 3.0 full-time equivalent (FTE) staff to 1.0 FTE PCP. Panel sizes for PACT teamlets may vary, but must be sufficient to ensure that all patients assigned to the teamlet panel receive appropriate and desired health care. The typical baseline panel size is 1200 for physicians, and 900 for APNs or PAs, but the size may be adjusted according to available support staff, space (i.e., exam or treatment rooms) and/or patient complexity (i.e., panels of complex patients, such as those with spinal cord injuries (SCI) will be smaller than those for patients needing only general health care).

The Medical Center has a total of 35 PACTs, of which Towbin has 22: 19 PC, 2 geriatric, and 1 SCI. On December 11, 2014, VA reviewed the appointment schedules of all 22 Towbin PACTs for the next available patient appointment dates, excluding follow-up appointments dependent on the specific PACT. The availability ranged from December 12, 2014 to February 7, 2015, (1 to 58 days) with an average of 11 days. There are currently four PCP vacancies; five part-time physicians and two float PCPs cover these current vacancies. Medical Center leadership has been actively recruiting to fill these vacancies; the HR office announced them three times in 2014 (January 24-February 7; April 17-April 25; and June 17-August 8) without getting any qualified applicants. In August 2014, HR posted a standing open vacancy announcement that includes a recruitment incentive bonus; they have now hired three APNs who are completing their credentialing process. One of them is now in orientation and will be assigned to cover one of the PACTs.

In its review of meeting minutes, emails, New Patient Wait Time Benchmarks, and other access data, VA found evidence that there had been a backlog of PACT appointments for new patients seeking to enroll into PC in the past. In March 2012, the NEAR List identified over 500 waiting patients.³ Medical Center leadership chartered a systems redesign team to monitor, track, and trend new patient wait time benchmark data on a monthly basis. Additionally, the newly assigned ACOS, PC/ED worked with the Deputy ACOS, PC/ED to formulate strategies to reduce the wait list, and on March 27, 2012, the Medical Center implemented its APN New Patient Process to give patients quick access. This process designates two APNs to process initial patient examinations, taking a comprehensive history, conducting a physical and assessment, and expediting the handoff of the Veteran to the appropriate PACT PCP. The process requires each PCP to block 1 hour daily in his or her schedule for new patient appointments and added a Saturday (extended hours) clinic in July 2014, to meet the VHA mandate to reduce patient wait times. This clinic allows additional access and accommodates patients who have scheduling conflicts during the week. From March 2012 to March 2013, the NEAR List dropped from over 500 down to 50, and since March 2013, the Medical Center has consistently scheduled new patients in less than 30 days, unless the patient desired a later date. PC leadership reports that current availability in the

³ **New Patient Wait Time Benchmark data** - measures percentage of patients seen within 14 days of appointment create date and average wait time in days. VSSC/SAIL-VHA Support Service Center (VSSC) Web site (<http://vssc.med.va.gov>). The **NEAR Call List** is a tool to be used by enrollment staff to communicate to PCMM Coordinators or schedulers, at the Veteran's designated preferred location, that a newly enrolled Veteran has requested an appointment during the enrollment process. VHA Directive 2010-027, VHA Outpatient Scheduling Processes and Procedures, 2e. (7), June 9, 2010.

New Patient Clinic is within 2 weeks. The ACOS PC/ED reported that if a patient calls and wishes to be seen sooner, the patient is usually accommodated within a week. As of December 23, 2014, the Medical Center had one pending case on the NEAR List; it is working with that Veteran to schedule a desired date.

2b. PACT providers see an insufficient number of patients to reduce wait times, and some PACTs only see four to five patients daily. An email dated October 7, 2013, from (b)(6) the Associate Chief of Staff for PC, scrutinizes the performance of PACTs, and suggests that providers intentionally see an insufficient number of patients. In this email, (b)(6) instituted a standard schedule for PACT teams to address this problem, which calls for teams to see 14 to 19 patients per day. In June 2014, the whistleblower reviewed a group of PACT schedules and determined that some teams still only treat four to five patients per day. He explained this workload causes excessive delays in appointments.

Findings

Two interviewed MSAs reported that PCPs in the Geriatric PACTs formerly only saw patients who were 55 and over: because of that age restriction, they often saw only 2–3 patients per day. The PCPs maintained that these patients moved slowly and needed more time than younger ones to get in and out of the examination rooms. On October 7, 2013, the ACOS, PC/ED became aware of this situation and informed his staff that this practice was unacceptable; he also developed a standardized scheduling template, provided guidance, education, and training in its use to the staff.

VA found that this scheduling template consisted of 8 routine patient appointments, 3 same-day appointments, and 4 telephone appointment slots, for a total of 15 possible appointments per day.⁴ During the site visit, the PCPs and other clinical staff consistently reported that they were seeing 8–10 patients per day with 4 same-day/walk-up slots. Several PCPs routinely saw 11–12 patients per day. In our review of the schedules, we found that all but one of the PACT PCPs saw patients according to the template; the exception was the newly assigned PCP in the process of orienting to her PACT. The ACOS, PC/ED had allowed her to schedule 6 routine patient appointments daily during her orientation period. According to VISN Support Service Center (VSSC) PACT Compass data for September 2014 year-to-date (YTD), the Towbin PCP's average panel (PCP/AP adjusted) size is 1,167.⁵ In comparison, the Medical Center's, including other CBOCs, is 1,055, that of VISN-16 is 1,117, and that of VHA is 1,068.

⁴ Same-day access is the ability to schedule an appointment within one business day of when the patient contacts the facility. VHA Handbook 1101.10, Patient Aligned Care Team (PACT) Handbook, 4aa, page 6.

⁵ The Patient Aligned Care Teams Compass brings together a series of metrics that reflect the dimensions and principles of the PACT to indicate whether a facility is on the right path. The metrics in the compass are based on patients assigned in PCMM to a PCP. The Compass provides facility leadership and PC managers and staff access to data on PC Panel Management, including PC Staffing Ratio; Medical Home Builder Survey responses, Inpatient Utilization metrics and ER/Urgent Care Utilization metrics.
<https://securereports2.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fPC%2fPC+Medical+Home%2fMainMenu&rs%3aCommand=Render>.

The ACOS, PC/ED used the overall number of encounters and clinic utilization of appointments to monitor the PCPs' performance and productivity and included this information in his/her performance evaluation. In addition, he counselled both PCPs who were not adhering to the recommendations to change their scheduling. VA found when reviewing the PACT provider's files that the ACOS PC/ED actively monitors and documents performance.

2c. Each PACT has designated times for same day access, but they are rarely used.

Findings

Upon review of the PACT schedules, VA found that Towbin routinely blocks three open appointment slots for same-day appointments: 8:00 a.m., 11:30 a.m. and 2:00 p.m. During interviews, the different PACTs reported variable usage of the same-day appointment slots; some saw one to two walk-up patients daily and others saw only one per week. According to VSSC PACT Compass, the Same Day Appointment utilization data for FY 2014 for the Medical Center is 70.54 percent, for VISN-16 it is 65.22 percent, and for VHA it is 65.69 percent. The Medical Center has approximately 30 percent of same-day open appointment availability.

2d. Instead of assessing the acuity of walk-in patients' symptoms, staff informs the individuals that the clinic no longer accepts walk-ins, and directs them to the Emergency Department. The practice of rejecting walk-in patients places an increased strain on the Emergency Department, which is inundated with rejected PACT patients seeking treatment for acute, non-emergent conditions.

Findings

MSAs are responsible for scheduling and rescheduling appointments, checking patients in and out, and ordering labs, etc., for the eight routine patient appointment slots; RNs are responsible for triaging patients who present without an appointment and scheduling them into the same-day slots. All staff interviewed accurately described the process for same-day appointments, knew that the RN had to perform an assessment on the patient, and knew that the patient should be scheduled within 24 hours of his/her request to be seen. However, VA found several emails where patients had reported to ED nursing staff that they had been told to go to the ED for non-urgent care. The ACOS, PC/ED reported that there was one RN who admitted that she had told a patient that the Medical Center did not take "walk-ins," and told the patient to go to the ED; she was subsequently counseled. The ACOS PC/ED emailed PC staff on January 21, 2014, stating that "Primary Care operates clinic by appointment. Patients are to call, send a secure message, or walk up and request an appointment to be seen." The next day, he sent a follow-up email reminding the PC staff to "manage your PACTs," stating that the "most inefficient way is to walk-in." In this email, he provided guidance on how to handle walk-ups: "The MSA is to have the PACT RN contact the

patient and coordinate the care and/or use a same day appointment or help them with their issue. Do not send them to the ED unless they have a medical emergency like chest pain, uncontrolled bleeding, or an acute neurologic deficit.”

On March 12, 2014, an ED RN sent an email to the ACOS PC/ED, noting that he had started triaging patients at 9:30 p.m. and that four out of the first five patients told him that they had called their PCP during the day and had been told that it would be 2 weeks before they could get an appointment, and to go to the ED if they needed to be seen before that. The RN noted that all of these patients had minor complaints which could have been handled quickly. In addition, the ED Nurse Manager disclosed, while sharing two corroborating emails, that nursing staff had reported patients stating that when they called Towbin in an attempt to reach their PACT, they had been told by staff to go to the ED. The ACOS, PC/ED had a joint meeting with the ED and PACT leadership to discuss this issue and sent out a follow-up email to the PACT staff, again with specific instructions on how to handle patients who walk in without an appointment and warning against the inappropriate practice of telling patients to go to the ED.

The ED, located at the Medical Center, has 3 sections: ED 1 has 12 monitored beds; all Level One, Two and Three; emergent care patients are treated in these rooms. ED 2 has 6 rooms; Level Four and Five; urgent care patients are treated in this area, and it is considered the “fast track” ED, where the patients with chronic and minor illnesses are seen; ED 3 is the chest pain center and has 6 monitored beds.⁶ The ED Nurse Manager reported that they were able to accommodate patients who were self-referred (i.e., they either wanted to go to the ED or could not get in touch with their PCP and walked into the ED) or were sent by the clinic.

VA found evidence that PACT staff may have directed patients to the ED in the past, but after meetings held between PC and ED leadership, emails to all staff, and continuing education, no recent instances have been reported. The ED leadership is currently monitoring, and tracking any occurrences and communicating findings to the PC leadership.

Conclusion for Allegation # 2

- **VA did not substantiate** that patients do not receive timely care from PACTs because providers do not treat a sufficient number of patients.

⁶ ED Levels of Care: **Level One** patients require immediate physical evaluation and treatment by a physician. High-risk conditions such as severe trauma, head fractures, respiratory distress and other life-threatening conditions are classified as level one. **Level Two** patients are seen as acute distress, they have time-sensitive complaints such as stroke symptoms and chest pains. Triage nurses dispatch these patients to emergency beds, where nurses administer resources, such as intravenous fluids or oxygen, before a physician sees the patient. **Level Three** patients, though considered urgent, have less acute conditions that require two resources, determined through vital signs taken during triage intake. Urgent issues include less severe psychiatric conditions or a pregnant women going into labor. **Level Four** patients require one resource, as determined by the triage nurse. A fracture with severe pain is a condition that is an example, because an X-ray is the only resource required for care. **Level Five** patients require no resources. Conditions such as fevers and common cold symptoms fall under this category; they are treated and discharged quickly.

- VA **substantiated** that, in the past, the PACT had a backlog of new patients waiting to be seen, but currently does not have a backlog.
- VA **did not substantiate** that same-day appointments are rarely used, but are used appropriately 70 percent of the time.
- VA found that the same-day appointments slots are used variably by different PACTs, and better management may facilitate the scheduling process.
- VA **substantiated** that patients had been told to go to the ED; however, this practice was appropriately addressed by management.

Recommendations to the Medical Center:

1. Reevaluate the management of same-day appointments to better utilize available providers to increase access, while ensuring the availability of same day appointments.
2. Continue the efficient management of patients on the NEAR list.
3. Continue the ongoing collaborative efforts between the ED and PC and ensure a process for communication.
4. Monitor, track, and trend PC PACT patients that present to the ED with Level V triaged complaints for opportunities for improvement.

Allegation # 3

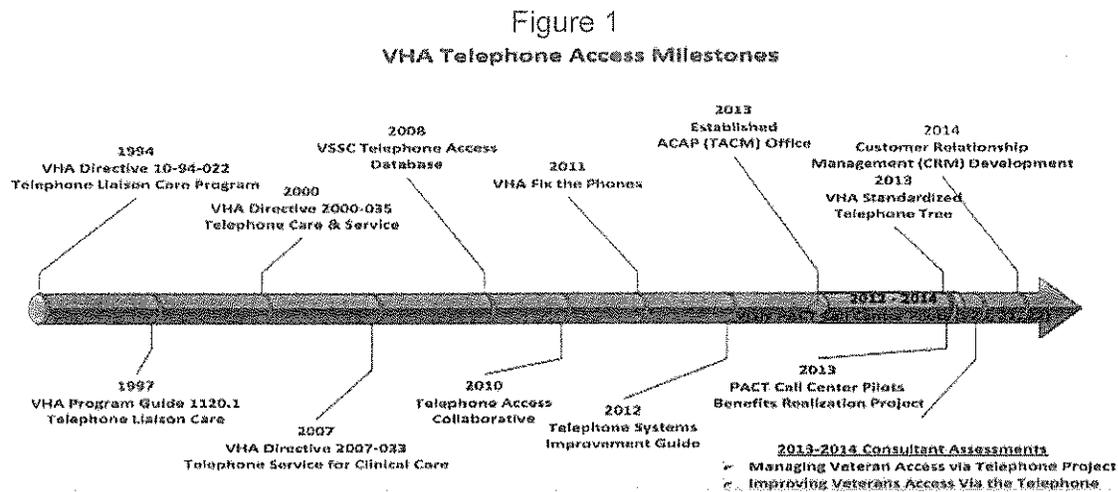
Deficiencies in the PACT telephone system create barriers to patient care.

3a. There are problems with the facility's telephone system, preventing veterans from scheduling appointments. Patients receive reminder letters shortly before appointments with incorrect or outdated PACT telephone numbers. In August 2013, information technology administrators changed all the PACT phone numbers, without updating numbers on correspondence sent to patients. This prevents patients from reaching their PACTs, resulting in delayed care.

Findings

Telephones and VHA

VHA has recognized problems with the link between Veteran access and the telephone system and has been working on improvements for many years.⁷ Figure 1 is a timeline diagramming the milestones described in the referenced working document.



Providing high quality telephone access to Veterans varies significantly throughout the system. The above referenced working document notes several factors that limit – improvement, including, but not limited to, technology resource and expertise limitations, and inadequate staff resources. The paper notes that only VISN 1 maintains a VISN-Level, dedicated FTE for field-level expertise in the design, implementation, and sustainment of call management systems.

VHA Directive 2007-033 established the policy for the provision of telephone service related to clinical care. It required all sites with more than 5,000 active PC patients and all VISN and Regional Call Centers implement call management software, Automated Call Distribution (ACD) to collect on an ongoing basis the following measures: call volume, answer speed, abandonment rates, and (an optional May 2014 update) blockage rates.⁸

⁷ VHA Telephone Access White Paper, December 12, 2014, VHA Offices of Primary Care Service (910P4F), Primary Care Operations (10nc3), and Access and Clinic Administration Program (10NA12)—working document.

⁸ **Automatic Call Distribution System.** The ACD is a specialized telephone system (software application) used in incoming call centers. Basic ACD capabilities include routing calls; sequencing calls; queuing calls; encouraging callers to wait (by playing delay announcements and, in some cases, predicting and announcing wait times); distributing calls among agents; capturing planning and performance data, both real-time and historical; and integrating with other systems. **Call Volume-** The number of calls coming into a telephone system including distribution by time of day and day of week. **Abandonment Rate-**The percentage of calls coming into a telephone system that are terminated by the persons originating the call before being answered by a staff person. **Answer Speed-**The average delay in seconds that inbound telephone calls encounter waiting in the telephone queue of a telephone service system before answer by a staff person. **Blockage rate-**the percentage of calls coming into a telephone system where the caller receives a busy signal. **Call Center.** A call center is a coordinated system of

The recent 2013-2014 Managing Veterans Access via the Telephone (MVAT) Project partnered the Access and Clinic Administration Program Office, and a KT Consulting/Booz Allen team to develop a menu of best practices and foundational elements for effective call management. Implementation is projected to take 3–5 years.

Telephones and the Medical Center

The Medical Center has had a long history of problems with its telephone system; it was slated to get a new system in 2011, which would have supported ACD data collection. When another facility's system crashed and took priority, the Medical Center's system replacement was postponed.

In September 2012, Medical Center leadership chartered a telephone systems redesign (SR) initiative and in February 2013, formed a Telephone Improvement Service Workgroup (TelGroup) composed of the Deputy ACOS, PC, and the Executive Assistant (EA) to the ADPCS/NE, a PC Program Analyst, two OIT technicians, and the MSA Supervisor) that met monthly to consider telephone issues throughout the Medical Center. In June 2013, the OIT made an attempt to activate the ACD system with Pathfinder software; however, the attempt was unsuccessful as the current system could not support the software; the SR minutes noted that they would revisit activating ACD in 2014.

During its investigation of this allegation, VA found two events related to the management of the telephone system that resulted in limiting Veterans' access. From March 1 to August 2, 2013, the Medical Center moved PACT staff from its facility to Towbin. With the move of the last 9 of the 22 teams, the Medical Center programmed new telephone numbers for the PACTs to accommodate the change in telephone servers with the location. They reported that neither the MSAs nor the patients had been provided with the new correct numbers; even the computer-generated appointment reminder letters lacked them; thus, many Veterans had difficulty reaching their PACTs. Once PACT clerks discovered the wrong numbers on the letters, they wrote the correct ones on the letters by hand prior to mailing, and they called the patients at home to give them the correct number. The facility's investigation into this issue revealed that the programmer had utilized an outdated list of PACT team phone numbers when programming the new server. This issue was resolved on December 16, 2013.

The second incident disrupting PACT access occurred in August 2014. In order to decrease the burden of the PACT MSAs answering telephones while dealing with clinic workload, the Medical Center decided to move their telephone calls to a centralized

people, processes, technologies and strategies that provides telephone access to organizational resources through appropriate channels of communication to enable interactions that create value for the patient and the organization. The types of call centers in VHA include: Local call center, which provides incoming telephone service for clinical care to one or more divisions of a VA facility and CBOCs. An example would be a call center handling the incoming telephone calls related to clinical services for the PACT teams. VHA Directive 2007-033, October 2007, *Telephone Access to Outpatient Clinical Care*.

appointment center. The TelGroup met frequently in preparation for the change. On August 5, the EA to the ADPCS/NE sent an email to the TelGroup verifying that the rerouting of the telephones to the centralized appointment center had been approved by the COS. The secretary of the COS sent a response noting that the COS approved. On August 11, the ACOS PC/ED sent an email to the PC PCPs, nurses, MSAs, CBOC Managers, the Deputy ACOS PC, and the TelGroup notifying them of the pending change. He noted "At the request of many MSAs, patient advocates, administrators and patients, we will begin with centralized appointment scheduling starting on August 28, 2014. The increasing demand for care in our clinics has overwhelmed the MSAs in each PACT trying to answer calls and negotiate appointments all while checking in patients, taking telephone messages, and assisting patients with other administrative [issues]. This has resulted in long wait times for patients on hold, lost calls, and decreased patient satisfaction. The patient advocates and PC administrative office get multiple calls daily from patients 'unable to get through to their PACT' in order to make an appointment." In addition, the Program Analyst sent an email notification to the MSAs and nursing staff. The Resources Committee minutes noted a need and request for 10 MSAs to support the appointment center.

After the workday of August 27, 2014, instead of the intended rerouting of the MSAs telephone lines, OIT rerouted not only their telephones, but also all PACT telephone lines for the nurses and doctors before the start of business on August 28, 2014. This resulted in no incoming calls on any PACT telephone line. The Medical Center reported there were four MSAs working the appointment center on August 27, and all the phones there were "ringing off the hook." As no one understood the rerouting to have occurred the appointment center MSAs attempted to send the calls back to the rerouted PACT telephone lines, which just rerouted the calls back to the appointment center. This issue more than doubled patient complaints, and greatly increased the frustration and dissatisfaction of patients and staff alike. The OIT programmer responsible had retired, making it difficult to undo the rerouting, and PACT MSAs had to augment the appointment center staff until the system was finally corrected on November 6, 2014. At the time of our visit, all 10 MSA positions have been filled. OIT and leadership reported that the Medical Center needs a new system in order to remedy many of the telephone issues, but it is not slated to receive one until 2016.

The Medical Center's Director at the time of August 2013 and August 2014, telephone issues, has retired. The other members of the Medical Center leadership were not able to describe oversight of the processes leading up to each event; however, they were able to articulate actions following both of these telephone issues.

The Strategic Analytics for Improvement and Learning (SAIL) documentation indicates that all primary care sites with more than 5,000 active PC patients and all VISN and Regional Call Centers must implement call management software to collect measures on their performance. Call center responsiveness assesses the average number of seconds in response to calls to centers. The quality improvement goal is for the average speed to answer at less than or equal to 30 seconds, and an abandonment rate of less than or equal to 5 percent.

Although VA received some ACD data from the facility, neither the staff nor the MSA supervisor was familiar with ACD call expectations, but they had heard about abandonment rates. The Medical Center's self-reported data to VSSC shows an Average Speed of Answer of 6 seconds and abandonment rate of 30.1 percent. The VA team tested response times by calling the PACT numbers; calls were not consistently answered within 30 seconds, and no calls were abandoned.

Although VA found multiple email messages that showed the extensive amount of time and effort that had been put into trying to correct telephone issues, staff complained about the past and ongoing problems with the telephone system at the Medical Center.

3b. A nurse reported a November 2013 incident in which a geriatric patient drove over an hour to walk-in at a PACT clinic because he could not schedule an appointment over the phone. The individual dialed an outdated number, and then was repeatedly cut off when he attempted to reach his PACT team by navigating menu options. The nurse reported that the patient attempted to schedule an appointment via phone for over a week before his medication finally ran out.

Findings

VA interviewed an RN who reported to the team about the November 2013 incident. She provided the Veteran's information, and a review of the patient's record revealed that the Veteran was seen and given a medication prescription the same day he arrived in the clinic. The Veteran had 30 contacts with the Medical Center entered in his EHR in the 2-month period before that date. The RN reported that the patient did not experience a negative clinical outcome as a result of running out of his medication, and was unaware of any patients who were clinically negatively impacted as a result of the phone issues.

3c. Patients were automatically placed on hold for 30 minutes before being cut off, and these deficiencies result in a higher number of walk-in patients. When walk-in patients are rejected it places a greater strain on the Emergency Department, which can delay emergency care for patients with serious emergent conditions.

Findings

No one at the Medical Center could provide information on a programed automatic function to disconnect Veterans on hold for greater than 30 minutes. In addition, one of the team's attempts to connect via telephone with a PACT finally resulted in a connection at 33 minutes; they were not disconnected. VA reviewed documentation on the phone system that noted that patient calls are automatically transferred to the appointment center after four rings if the PACT MSAs do not pick up their designated phones. One of the interviewees reported that there had been a past issue with the ACD, that if the Veteran did not make a choice to connect to a specific PACT (which is possible if the Veteran was confused by the choices), instead of defaulting to a

connection with the appointment center, the system would disconnect the call. The Medical Center was aware of this issue and working on it.

The ED Nurse Manager reported that her staff members continue to have difficulty telephonically connecting with PC, and this has resulted in a practice of providing the care needed in the ED instead of attempting to refer patients to their PACTs. The ED performance data did not show an increase in the number of Level Four and Five urgent care patients seen and did not support that problems with the telephone system resulted in a higher number of walk-up patients, or that any patients had a delay in emergency care coinciding with either the August 2013 or August 2014 phone issues. The ED Nurse Manager is currently tracking the number of walk-in patients sent from PC.

Conclusions for Allegation # 3

- VA **substantiated** that the Medical Center has significant problems with the current telephone system and its management. This has resulted in access difficulties, an increase in both patient and staff complaints, and the ED's inability to appropriately refer patients to PACTs.
- VA **was not able to substantiate** that patients' inability to reach their PACTs telephonically resulted in delayed care, as patients would walk-up to the clinic or come to the ED.
- Although VA found evidence that patients were told to go to the ED, in the past, no evidence was found that patients were harmed by being sent to the ED, and VA found no evidence that this is the current practice.
- VA did not find evidence of significant involvement by senior leadership in either the August 2013 or August 2014 telephone programming issues.
- The EA for the ADPCS/NE was integral in planning the transfer of MSA telephone calls to the appointment center, as well as attempting to correct the subsequent issues.
- VA found evidence that midlevel staff has been actively working on the telephone issue for at least 2 years.
- VA **was not able to substantiate** that patients were automatically placed on hold for 30 minutes before being cut off.
- VA is concerned that the current OIT staff does not have the skills and knowledge to correct the telephone problem throughout the Medical Center.
- VA is also concerned that similar telephone issues are not isolated to the Medical Center and may be present elsewhere in the system.

Recommendations to the Medical Center:

5. Train appropriate staff on the management of the phone system.
6. Train the appropriate staff on the reporting capabilities, specifically how to use the available data monitor operator performance, quality, access, and patient satisfaction.
7. Evaluate the functional requirements needed to bring the telephone system on line to meet not only the all current monitoring, tracking, and reporting requirements, but to improve communication between both the Medical Center and the Veterans, and other providers with the PACTs.

Recommendations to VA:

8. Conduct a VACO OIT assessment of the Medical Center's communication support and expedite the necessary changes to improve the functionality of the system.
9. Evaluate whether the lack of appropriate equipment and trained personnel to manage the system identified at the Medical Center are systemic to VA, and if so, develop a remediation plan.
10. Conduct an administrative investigation of the role of senior Medical Center leadership in the lack of adequate oversight of the Medical Center's telephone system's implementation and on-going management issues, and take appropriate action.

Allegation # 4

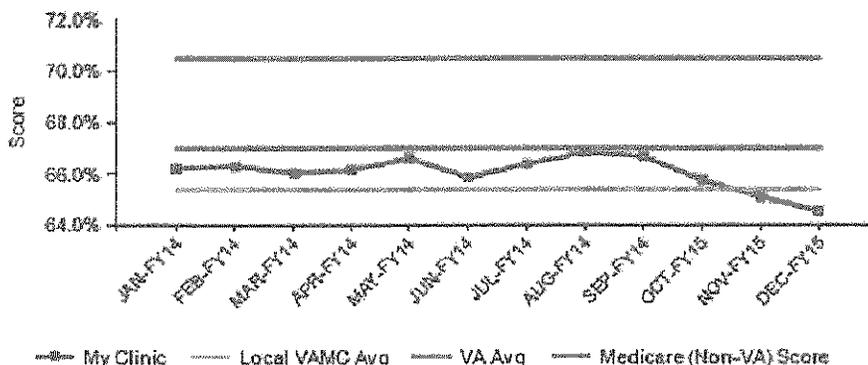
Management's failure to properly supervise PACTs endangered public health and safety.

Findings

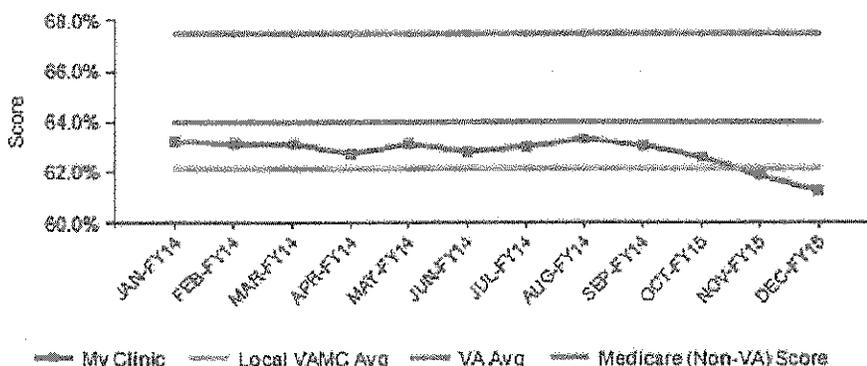
VA reviewed quality measures on the Medical Center PACTs. According to VHA's VSSC PC Divisional Data Charts, the Medical Center's performance for hypertension control for both diabetic and hypertensive patients overall had decreased.⁹ These charts represent Towbin PACTs' management of their diabetic and nondiabetic Veterans' blood pressure management.

⁹ VHA VSSC PC Divisional Data Charts – data showing Medical Center PC quality measures.
https://securereports2.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fPC%2fPCCharting%2fPCDivRunChart_PgeView.

(V16) (598A0) Central AR. Veterans HCS NLR
 Patients w/Diabetes: Good Blood Pressure Control (higher is better)



(V16) (598A0) Central AR. Veterans HCS NLR
 Patients w/Hypertension: Good Blood Pressure Control (higher is better)



VA also contacted the Director, Clinical Analytics and Reporting, who reviewed available data for the Medical Center. He stated that primary care is full of lagging indicators, which would result in a delay in the impact on care, good or bad; thus, making it difficult to make the available data either exculpatory or inculpatory. However, VA’s SAIL data provides some insights. SAIL uses a rolling 12-month average. The review of the Medical Center’s data revealed a Healthcare Effectiveness Data and Information Set composite score of 89 percent (range across VA is 87 to 93 percent; a score above 85 percent is acceptable). Ambulatory Care sensitive admissions is 29 per 1000 (range 23 to 37).

A review of Medical Center data for just the 4th Quarter 2014 reveals that its Ambulatory Care Sensitive Condition Hospitalizations (ACSC) admission rate is lower than expected (an indicator of ambulatory care that is effective in addressing preventable hospitalizations) and their performance on a variety of outpatient composites is not statistically different than VA overall.

Both datasets reveal that the Medical Center is “in the middle of the pack” among VA’s. Of note, the southeast United States regions in general perform more poorly among

Medicare and Commercial health plans; therefore, the Medical Center most likely does better than its local private sector peers.

Historically, PC has had a history of fragmented leadership due to a prolonged vacancy in the ACOS, PC, prior to the current one coming on board in April 2012. Interviewees identified the current ACOS, PC/ED and Deputy ACOS, PC as engaged, responsive, and a positive impact on the PC service. VA repeatedly found evidence that this current PC leadership has decreased the patient wait time, addressed patient flow issues between PC and the ED, and have attempted to address the telephone issues. The EA to the ADPCS/NE has also been very engaged and the point of contact for the significant telephone issues. As noted in the Findings for Allegation 2, the Medical Center upper level management was unable to articulate involvement in the planning for the August 2014 telephone switch, which resulted in significant telephone access issues for Veterans, and an increase in patient complaints. They reported becoming aware after August 27, 2014.

Conclusions for Allegation # 4

- VA **did not substantiate** that the PC leadership failure to properly supervise PACTs endangered public health and safety.
- Current data demonstrated an acceptable level of overall care in primary care; however, hypertension management may be improved.
- VA **substantiated** that upper level management was unaware of the seriousness of the telephone issues, which could potentially cause access issues for patients.
- The ongoing problems with the telephone system caused an increase in patient complaints and dissatisfaction.

Recommendation to the Medical Center:

11. Develop a focus on hypertension management to improve overall blood pressure control.

Recommendation to the VISN:

12. Review the role of senior leadership in the Medical Center's telephone system management. If there is a lack of knowledge, provide the appropriate training; if a lack of oversight, take the appropriate action.

VI. Summary Statement

VA has developed this report in consultation with other VA and VHA offices to address OSC's concerns that the Medical Center may have violated law, rule or regulation, engaged in gross mismanagement, an abuse of authority, or risked public health or

safety. In particular, OGC has provided a legal review and OAR has examined the issues from an HR perspective, establishing individual accountability, when appropriate, for improper personnel practices. VA did not find that the Medical Center had violated laws, rules or regulations, or posed a specific danger to public health but that there were past violations of the VHA policies mentioned above.

Attachment A

1. VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014.
2. VHA Handbook 1101.02, *Primary Care Management Module (PCMM)*, April 21, 2009.
3. VHA Directive 2010-27, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010.
4. Veterans Health Administration, *Telephone Systems Improvement Guide*, Second Edition, December 2011.
5. CAVHS Organizational Chart.
6. CAVHS Joint Commission Official Accreditation Report, Unannounced Full Event, August 11-15, 2014.
7. CAVHS Strategic Analytics for Improvement and Learning (SAIL) scorecard data, FY 2014.
8. Medical Center Congressional response on wait times, phone and appointment issues – August 2013- December 2014.
9. Medical Center Primary Care Organizational Chart, October 2014.
10. Medical Center Patient Advocate Tracking System, Primary Care Access Complaints, October 2012 – September 2013.
11. Medical Center NEAR List for November 3, 2014 and December 1, 2014.
12. Medical Center Issue Briefs on computer and phone issues.
13. PACTs patient appointment schedules and the next available appointment for all PACTs starting from December 12, 2014.
14. Primary Care PACT vacancies, December 24, 2014.
15. Patient Aligned Care Teams Compass, Data Definitions, June 24, 2014.
16. Primary Care VSSC PACT Compass Same Day Access report for fiscal year (FY) 2014 (October 1, 2013-September 2014).

17. Memorandum of Understanding Between Primary Care Service, Mental Health Service, Pharmacy Service, Laboratory Service, Radiology Service and Human Resources, Primary Care Service Extended Hours Implementation, July 2014.
18. ACD data on call center telephone response time and abandonment rates.
19. Medical Center Systems Redesign Minutes FY 2013-2014.
20. Office of Inspector General Office of Healthcare Inspection Combined Assessment Program report,
March 15, 2013.

