Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Delay in Care and Discourteous Employees at Michael E. DeBakey VA Medical Center Houston, Texas

Report No. 06-00207-159

June 30, 2006

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244

Executive Summary

The purpose of this inspection was to determine the validity of allegations of delay in care and discourteous employees at the Michael E. DeBakey VA Medical Center, Houston, TX.

Issue 1: Delay in Care. We did not substantiate the allegation that the patient waited 5 hours to be seen in the Triage Center. The patient waited just under 3 hours to be seen by a nurse in the Triage Center. We substantiated the allegation that the patient had not received an appointment at the time he made his complaint on September 8. However, the facility attempted to contact the patient on September 13 to notify him that he had a September 19 appointment in Primary Care Clinic.

Issue 2: Patients Passing Out In the Triage Center. We could neither substantiate nor refute the allegation that patients were passing out in the Triage Center.

Issue 3: Staff Ignore Patients. We could neither substantiate nor refute the allegation that staff ignores patients and keeps them waiting for long periods of time.

Issue 4: Medical and Pharmacy Staff. We could not substantiate the allegation that the medical and pharmacy staff's behavior "appeared to be paralyzed." The Triage Center nurse was the only medical staff member who had contact with the patient on the day of his visit. Pharmacy is not located in the Triage Center area; the patient did not have contact with Pharmacy Service staff, nor did he have a prescription filled by the pharmacy.

Issue 5: Administrative Assistant. We could neither substantiate nor refute the allegation that the Primary Care Clinic administrative assistant called the patient "to chew [him] out for complaining" and suggested he contact his congressman.

Conclusion:

We substantiated the allegation that the patient did not have a scheduled appointment at the time of his complaint. The patient left the Triage Center without being seen by a physician and therefore was not given a Primary Care Clinic appointment that day. However, on September 13, managers attempted to notify him of a September 19 appointment. We did not make any recommendations.

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

TO: Director, Veterans Integrated Service Network (10N16)

SUBJECT: Healthcare Inspection – Alleged Delay in Care and Discourteous Employees, Michael E. DeBakey VA Medical Center, Houston, TX

Purpose

The Department of Veterans Affairs Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI) reviewed allegations of delay in care and discourteous employees at the Michael E. DeBakey VA Medical Center (medical center), Houston, TX. The purpose of the inspection was to determine the validity of the allegations.

Background

Congressman Michael T. McCaul asked the OIG to review a case regarding the medical center Triage Center on the behalf of a veteran in Houston, TX. He is a non-service connected veteran (patient) who was last treated at the medical center for pain in his right leg and foot due to a gunshot wound in 1996.

The patient made allegations that he and other patients had delays in care and discourteous treatment by employees at the medical center. He did not provide the names of the other patients in the allegations. Specifically the complainant alleged that:

- He sought treatment in August 2005 at the medical center's Triage Center for a neck problem that causes numbness in his left hand when he holds his head up straight. [VA medical records show that he came in July 25, 2005.] After he got an identification card, he waited 5 hours to see a nurse who told him there was an 8-hour wait to see a doctor and a 6-month waiting period to schedule an appointment. As of September 8 (the date of his complaint letter), he had not received an appointment for his neck problem.

- There were several instances of patients passing out while in the waiting area.

- Medical center staff ignores patients and keeps them waiting for long periods of time.

- Medical center medical and pharmacy staff "appeared to be paralyzed" when it came to working with him.

- An administrative assistant called him at home "to chew [him] out for complaining" and suggested he contact his congressman.

The Triage Center is primarily a 24-hour triage unit for unscheduled and non-established patients[1] who present to the medical center seeking care on an outpatient basis. The Triage Center is staffed by trained nurses who determine the urgency of patient care needs and assist with routing to appropriate areas and coordination of care and services. According to the Triage Center protocol, all non-established patients will be assigned to a primary care team and provider[2] upon completion of the Triage Center visit. Appointments are governed by individual circumstances. The patient was considered non-established as he had not received VA medical care in 9 years.

Scope and Methodology

We conducted a telephone interview with the patient on November 16, 2005, and visited the facility on November 29–December 1. We interviewed the nurse involved in this case, the primary care director, other administrative staff, the eligibility supervisor, and the patient representative. We reviewed medical records and VHA directives pertinent to the case, patient complaints, quality management documents, local policies and procedures, and the Triage Center check-in logs. We conducted a general inspection of the Triage Center.

We conducted the review in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

[1] Veterans who have not received care anywhere in the VA system in over 2 years.
[2] A provider could be a physician, physician assistant, or nurse practitioner.

Case Review

The patient is a 50-year-old male who sought treatment July 25, 2005, for a neck problem that causes numbness and tingling in his left hand when he holds his head up straight. He requested medications for pain and gout that had progressively worsened over the past 9 months. He also requested that a primary care provider (PCP) be assigned to him. Medical center documentation indicates that the patient was alert and oriented and appeared comfortable and was not in acute distress. However, the patient had a reported pain score of 6 out of 10, signifying a severe level of pain. During his interview, the patient stated that he had been receiving medical care from a private physician.

The Triage Center nurse offered the patient the option to go to the Urgent Care Clinic where he would be seen that day. However, he chose to wait for a Primary Care Clinic (PCC) appointment. The nurse informed him that he would be given an appointment and assigned to a PCP as soon as possible. She provided a benefit booklet that included a telephone triage number to call and told him to return to the Triage Clinic if needed. The patient left the Triage Center before being seen by a physician or other provider, which is why he did not receive an appointment that day.

The patient was a "No Show" for his scheduled PCC appointments on September 19, October 13, and December 16. He was assigned a PCP at the time of the September 19 appointment.

The patient told us that he moved to Arizona and has been treated at the Northern Arizona Healthcare System in Prescott for his neck pain and left arm numbness. He is pleased with the medical care he has received. Documentation shows that the patient received medical care at the Northern Arizona Healthcare System on October 27.

Results

Issue 1: Delay in Care

We did not substantiate the allegation that the patient waited 5 hours to see a clinician in the Triage Center. We were unable to determine if the Triage Center nurse told the patient there was an 8-hour waiting period to see the doctor and a 6-month waiting period to schedule an appointment. We substantiated the allegation that the patient had not received an appointment at the time of his complaint.

The patient signed in for eligibility and means processing,[3] which is located in the medical center's Triage Center, at 10:42 a.m. on July 25. This application process was completed and he received his VA patient ID at 11:38 a.m. According to the Triage Center check-in log, the patient checked in at 11:48 a.m., and a triage nursing note was completed at 2:37 p.m. Therefore, the patient waited less than 3 hours to see the triage

[3] A process that determines a veteran's entitlement to medical care and the veteran's financial status.

nurse not the alleged 5 hours. A 3-hour wait for a non-emergent patient without a scheduled appointment would not be unusual in a busy clinic such as Houston's walk-in Triage Clinic.

The medical center uses national computer software that automatically generates electronic reminder letters to patients a few weeks prior to their scheduled clinic appointments. Additionally, a telephone reminder system is programmed to call patients on the business day prior to their scheduled appointment. The business office administrator assured us the patient received a letter and a call for each appointment but was unable to provide copies of the letters. The system generating the appointment letter is not designed to keep copies of the original letters.

In addition to reviewing the case described above, we reviewed a sample of 17 medical records that included established and non-established patients, to review timeliness of care. The medical records were for patients seen in the Triage Center during the week of July 25 and the first and fourth week in October 2005. Fifteen of the 17 patients received appointments within 1 month of their Triage Center visit. Two non-established patients were given appointments in 2 and 5 months respectively. These two patients only wanted to have their prescriptions from a private health care provider filled at the medical center and were considered to have non-urgent conditions.

Issue 2: Patients Passing Out

We could neither substantiate nor refute the allegation that patients were passing out in the Triage Center.

The patient stated, "I saw a guy humped over in a wheel chair waiting for 4 to 5 hours to be seen…The man fell over and they rushed him off…." He also said, "I saw a patient collapsed in the bathroom, but I do not know what happened to him."

The administrative staff denied the allegations. They stated that there had never been a situation of patient unresponsiveness in the Triage Center. The nurse manager collects a daily Administrative Activity Report, completed by the clinic nurses, that includes special incidents. The report completed for the date of July 25 did not reflect any patient incidents.

Issue 3: Staff Ignore Patients

We could neither substantiate nor refute the allegation that staff ignores patients and keeps them waiting for long periods of time.

While we were not able to determine if this specific allegation has merit, the administrative staff provided quality management data that showed sustained performance improvements regarding patient waiting times in the outpatient setting.

The Primary Care Line, which includes the Triage Center, collects and critically analyzes quality management data for new and non-established patients regarding access to care and patient waiting times in the outpatient areas. This data shows continued performance improvement.

The Director of the Triage Center explained other efforts that have been implemented to shorten waiting times and to improve access to care:

- A contract physician was hired to see the patients who were on the Primary Care Clinic waiting list, and the waiting list was significantly reduced.

- An additional primary care team is being established to accommodate the increasing workload and eliminate the need for a waiting list.

The medical center patient representative provided documentation that showed only seven staff courtesy incidents had been reported from November 2004–November 2005.

Issue 4: Medical and Pharmacy Staff

We could not substantiate the allegation that the medical and pharmacy staff's behavior "appeared to be paralyzed" when working with the patient.

The Triage Center nurse was the only medical staff member who had contact with the patient on the day of his visit. Pharmacy is not located in the Triage Center area; the patient did not have contact with Pharmacy Service staff, nor did he have a prescription filled by the pharmacy.

Issue 5: Administrative Assistant

We could neither substantiate nor refute the allegation that the Primary Care Clinic administrative assistant called the patient "to chew [him] out for complaining" and suggested he contact his congressman.

The administrative assistant who serves as a Patient Relations Assistant of the Primary Care Line denied the allegation. She stated, "I am here to help veterans solve problems and that is very rewarding. We help veterans maneuver through the system to expedite accommodations for the veterans." During our interview with the patient, he said that the administrative assistant told him, "if he wanted to be treated to come to the Emergency Room (ER) on the weekends." The administrative assistant denied the allegation and stated, "It does not make sense, and I do not see the logic in asking the veteran to come to the ER for treatment on the weekends. The ER is open 24/7 and he was offered to go to ER the day he came."

The patient representative told us that this is the first complaint she has received pertaining to the administrative assistant. The director of the Primary Care Line and the administrator of the Triage Center stated that the administrative assistant's conduct or

performance had not been an issue. The Triage Center administrator identified that this employee is part of the Customer Service Recovery Team and a valuable resource person for resolving patient issues. She also stated that the administrative assistant is a very dedicated employee.

Conclusion

We substantiated that the patient did not have an appointment on September 8 when he made the complaint. However, on September 13, managers did attempt to contact him concerning a September 19 scheduled Primary Care Clinic appointment. The patient has since moved to another state and is pleased with his VA care there. We do not make any recommendations.

VISN and Medical Center Director Comments

The VISN Director and Medical Center Director concurred with the results of this inspection.

Assistant Inspector General for Healthcare Inspections

The VISN Director and Medical Center Director agreed with the findings and conclusions in this inspection report.

(original signed by Dana Moore,
Deputy Assistant Inspector General for
Healthcare Inspections for:)

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 1, 2006

From: Director, Veterans Integrated Service Network (10N16)

Subject: **Michael E. DeBakey VA Healthcare System, Houston, Texas**

To: Department of Veterans Affairs Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI)

The South Central VA Health Care Network concurs with the Draft Report – Healthcare Inspection – Alleged Delay in Care and Discourteous Employees, Michael E. DeBakey VA Medical Center, Houston, Texas – Project Number: 2006-00207-HI-0188.

If you have any questions, please contact Mary Jones, at 601-364-7871.

(original signed by:)

Robert Lynch, MD

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

The following VISN Director's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

OIG Recommendation(s)

We offer no recommendations as result of this inspection.

VISN 16 Response: We concur with the report.

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 1, 2006

From: Medical Center Director (580/OO)

Subject: **Michael E. DeBakey VA Healthcare System Houston, Texas – OIG Hotline Report – Delay in Care**

To: Department of Veterans Affairs Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI)

Director, Veterans Integrated Service Network (10N16)

1. This correspondence is in response to your April 27, 2006 request for review and comments of subject draft report.

2. After long and thorough review to include trending, comparison against benchmarks and assurance that all of our ACA criteria have been covered, the Michael E. DeBakey VA Healthcare System concurs with the OIG draft report.

3. Thank you for the opportunity to provide a response on these issues.

(original signed by:)

EDGAR L. TUCKER

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

The following Medical Center Director's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

OIG Recommendation(s)

We offer no recommendations as result of this inspection.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Marilyn Walls, Healthcare Inspector, Dallas Office of Healthcare Inspections
Acknowledgments	Linda DeLong, Director Karen Moore, Associate Director Roxanna Osegueda Wilma Reyes

Appendix D

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