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Office of Inspector General**

Office of Healthcare Inspections

Report No. 14-03822-359

Healthcare Inspection

Alleged Provision of Care, Nursing Supervision, and Scheduling Issues at Community Based Outpatient Clinics at the Amarillo VA Health Care System Amarillo, Texas

September 7, 2017

Washington, DC 20420

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Executive Summary

At the July 2014 request of Congressman Mac Thornberry, the VA Office of Inspector General conducted a healthcare inspection to assess allegations at the Amarillo VA Health Care System (facility), Amarillo, TX, concerning (1) provision of care at the Childress, TX, and Clovis, NM, community based outpatient clinics (CBOC); (2) nursing supervision at the Childress, TX, CBOC; and (3) scheduling issues at the Lubbock, TX, CBOC. We subsequently received and reviewed additional allegations concerning the provision of care at the Childress CBOC. The specific allegations were:

1. The Clovis and Childress CBOCs had greater than 100 patients who were not seen by a primary care provider for more than 1 year.
2. The Childress CBOC had inadequate space to provide patient care and privacy for veterans and staff, and to store medical equipment. Additionally, the CBOC did not meet Veterans Health Administration (VHA) environment of care requirements for the provision of care to women veterans.
3. The Childress CBOC did not provide the same level of care as provided at the facility.
4. The Childress CBOC Registered Nurses (RN) and Licensed Vocational Nurses (LVN) performed clerical work such as answering telephones, scanning, faxing, and scheduling patient appointments because the facility did not assign clerical staff.
5. Childress CBOC nurses lacked supervisory oversight from the facility and may have been doing triage which was out of their scopes of practice.
6. Lubbock CBOC staff were not trained in scheduling patient appointments.
7. Lubbock CBOC staff destroyed records, kept paper lists, and changed dates when patients wanted to be seen.

We substantiated that from November 2012 through November 2014, the Clovis and Childress CBOCs had greater than 100 patients who had not been seen by a primary care provider for more than 1 year, and that 3 patients may have been adversely impacted by a lack of follow-up care at the Clovis CBOC. However, we did not find a requirement that patients be seen yearly. Frequency of follow-up visits should be determined by the provider and patient and varies based on comorbidities, medical history, age, prescribed therapies, and patient/provider preference.

We did not substantiate that in March 2016, the Childress CBOC had inadequate space to provide patient care and ensure privacy for staff and veterans. We found that staff were able to provide patient care and ensure auditory privacy for veterans and staff by using white noise machines. We determined that the Childress CBOC met VHA environment of care requirements for the provision of care to women veterans.

We did not substantiate that in January 2015, Childress staff did not provide comprehensive care or the same level of primary care to patients at the CBOC as provided at the facility. Services that were not available on-site were offered via other mechanisms such as telehealth or referrals. We determined that rapid testing supplies and/or equipment were not available due to space issues and that the Tetanus, Diphtheria, Pertussis (Tdap) vaccine was occasionally in short supply in 2015 and 2016, but the shortage issue was resolved in 2017. When laboratory tests, radiology tests, specialty care, or vaccinations were required but not available at the CBOC; the Childress CBOC PCP referred patients to other VA or non-VA facilities.

We noted that limited space was available to store medical equipment and that staff used the Clinical Video Teleconference Room and laboratory alcove for equipment storage.

We substantiated that in January 2015, RNs and LVNs performed clerical duties because the facility did not assign clerical staff to the CBOCs. However, this was not a violation of VHA policy and allowed for cross coverage of clinical and clerical duties.

We did not substantiate that in January 2015, nurses at the Childress CBOC lacked supervisory nursing oversight. Neither VHA nor facility policy require on-site nursing supervision at CBOCs. Although nursing supervisors made infrequent visits to the Childress CBOC, nursing staff were supervised and able to contact supervisors by phone and email. We substantiated that LVNs may have exceeded their scope of practice when an RN or PCP were not physically present at the clinic. After our 2015 visit, facility staff instituted a new process to provide patients access to an RN and/or a PCP by phone when an RN or PCP was not available on-site.

We did not substantiate that in August 2014 Lubbock CBOC staff lacked training in scheduling patient appointments. We found that all Lubbock scheduling staff had completed the required scheduling training.

We did not substantiate that in August 2014 Lubbock CBOC staff destroyed documents and kept paper wait lists. We interviewed 18 schedulers and determined that they were not aware of destruction of documents or the use of paper wait lists. In response to similar allegations, VAOIG Office of Investigations issued an *Administrative Summary of Investigation* report in March 2016 that did not support manipulation of data or destruction of paper wait lists by Lubbock CBOC staff.¹

We recommended that the Amarillo VA Health Care System Director ensure that:

- CBOCs are appropriately staffed to provide care.

¹ VAOIG Office of Investigations. *Administrative Summary of Investigation by the VA Office of Inspector General in Response to Allegations Regarding Patient Wait Times, Endoscopy Clinic Amarillo at the VA Medical Center Texas Outpatient Clinic Lubbock at the VA Medical Center, Texas.*, (Report No. 14-02890-152, March 8, 2016).

- Managers conduct clinical reviews of the three Clovis CBOC patients discussed in this report to determine whether a delay in follow-up adversely affected their outcomes and take action as appropriate.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 18–21 for the Directors’ comments.) For recommendation 2, with a completion target date of July 31, 2017, we will follow up on the recently implemented actions to ensure that they have been effective and sustained. We will follow up on the planned actions for the remaining open recommendation until completed.



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Purpose

At the July 2014 request of Congressman Mac Thornberry, the VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations at the Amarillo VA Health Care System (facility), Amarillo, TX. The allegations concerned provision of care at the Childress, TX, and Clovis, NM, community based outpatient clinics (CBOC); nursing supervision at the Childress, TX, CBOC; and scheduling issues at the Lubbock, TX, CBOC. We subsequently received and reviewed additional allegations concerning the provision of care at the Childress CBOC.

Background

The facility is part of Veterans Integrated Service Network (VISN) 17 and provides care to approximately 25,000 patients annually in the Texas and Oklahoma panhandles, eastern New Mexico, and southern Kansas. The facility maintains 55 acute care inpatient beds for general medicine, surgical, and intensive care and provides geriatric and extended care in a 120-bed skilled nursing home care unit. Four CBOCs are located in Lubbock, Childress, and Dalhart, TX, and Clovis, NM.

Facility CBOCs

The Clovis, Childress, and Dalhart CBOCs are located in rural areas, 77 to 119 miles from the facility. The Lubbock CBOC is a multi-specialty facility located in an urban area 131 miles from the facility.

Clovis, a town of approximately 39,500 residents, is 106 miles from the facility and is medically served by a 106-bed non-VA regional medical center and a United States Air Force Medical Treatment Facility. The Clovis CBOC is a stand-alone clinic providing primary care. In August 2014, two full-time primary care providers (PCP) were employed at the CBOC.² In October 2014, one PCP left. Additional staff included two Registered Nurses (RN) and one Licensed Vocational Nurse (LVN).

Childress, a town of approximately 6,100 residents, is 119 miles from the facility, and is medically served by a 39-bed non-VA hospital. This CBOC is co-located in a non-VA community medical clinic and offers primary care and mental health. In August 2014, staffing included one part-time PCP who saw patients at the CBOC 2 days per week, one full-time RN, and one LVN. In December 2014, the RN resigned.

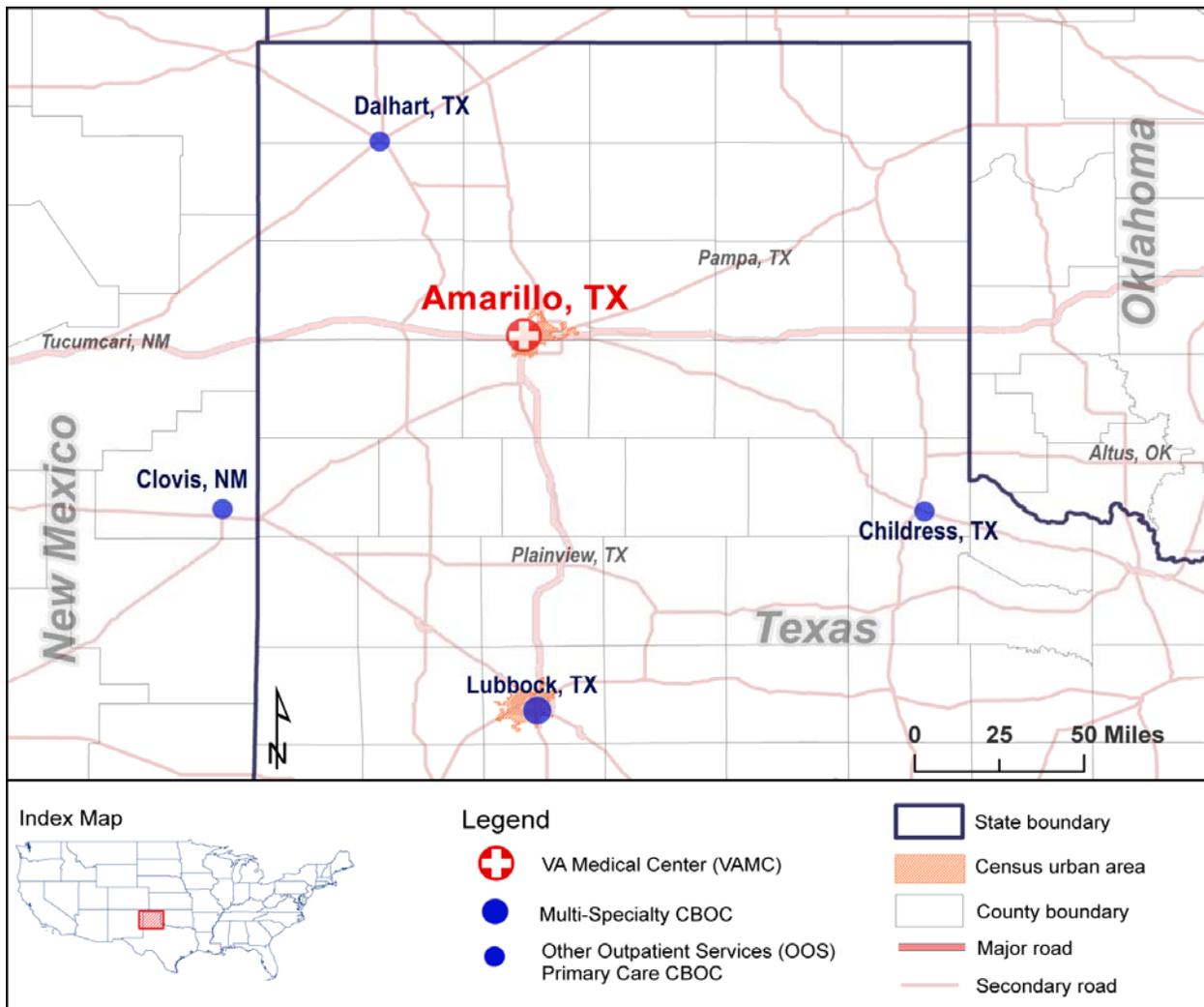
Dalhart, a town of approximately 8,000 residents, is 77 miles from the facility, and is medically served by a 25-bed non-VA hospital. The CBOC is a stand-alone clinic offering primary care. In August 2014, the CBOC did not have a permanent PCP.

² VHA Handbook 1101.10, *Patient Aligned Care Team (PACT)*, February 5, 2014, pp. 5-6, defines a Primary Care Provider as a physician, advanced practice registered nurse, or physician's assistant who provide primary care to an assigned panel of patients and in accordance with licensure, privileges, scope of practice or functional statement.

However, a PCP from the facility traveled to the CBOC one day per week to see patients. Additional CBOC staff included one RN and one LVN.

The Lubbock CBOC is the largest of the facility’s four CBOCs and is located in a city of approximately 230,000 residents 125 miles from the facility. Three medical systems, including Texas Tech Medical School, serve the city. Services offered at this CBOC included primary care, specialty care, and mental health care. In August 2014, 8 full-time and 6 part-time PCPs, 22 RNs, and 11 LVNs were assigned to the Lubbock CBOC. The CBOC also offered onsite laboratory and pharmacy services.

Figure. Map of Facility and CBOCs.



Source: VA OIG April 1, 2016

Texas Physician Shortage

According to a 2015 study on Texas physician shortages, “35 Texas counties have no practicing physicians, and 80 counties have 5 or fewer practicing physicians.”³ In 2015, Texas ranked 47 out of 50 states due to its chronic shortage of primary care physicians.^{4,5} Childress, Clovis, and Dahlhart CBOCs are located in rural communities designated by the U.S. Department of Health and Human Services, Health Resources and Services Administration as “health professional shortage areas.”⁶ In order to be classified as a health professional shortage area, the following three criteria must be met:

1. *The area is a rational area for the delivery of primary medical care services.*
2. *One of the following conditions prevails within the area: (a) the area has a population to full-time-equivalent primary care physician ratio of at least 3,500:1. (b) The area has a population to full-time-equivalent primary care physician ratio of less than 3,500:1 but greater than 3,000:1 and has unusually high needs for primary care services or insufficient capacity of existing primary care providers.*
3. *Primary medical care professionals in contiguous areas are overutilized, excessively distant, or inaccessible to the population of the area under consideration.*⁷

Allegations

In July 2014, OIG received a letter from Congressman Thornberry with allegations from an anonymous complainant. We subsequently received additional allegations from another complainant regarding care at the Childress CBOC. We addressed concerns related to CBOCs in this report. Other concerns are addressed in a separate publication.⁸ This report addresses the following allegations:

1. The Clovis and Childress CBOCs had greater than 100 patients who were not seen by a primary care provider for more than a year.

³ Goodman, Matt, Statewide Study Illustrates Physician Shortage Across Specialties In Urban, Rural Areas, *D. Healthcare*, April 29, 2015 <http://healthcare.dmagazine.com/2015/04/29/statewide-study-illustrates-physician-shortage-across-specialties-in-urban-rural-communities/>. Accessed January 11, 2017.

⁴ Singleton, Travis, THE PHYSICIAN WORKFORCE IN TEXAS, *An Examination of Physician Distribution, Access, Demographics, Affiliations, and Practice Patterns in Texas’ 254 Counties*, Merritt Hawkins, April 2015 https://www.merrithawkins.com/UploadedFiles/MerrittHawkings/Surveys/Merritt_Hawkins_NTREC_Physician_Workforce_Survey.pdf. Accessed April 4, 2017.

⁵ Ranking worsened since 2007. In 2007, Texas ranked 43rd out of 50 states with 157 practicing physicians per 100,000 population - the same number it had in 2000. Texas Medical Association Legislative Brief 2009. <https://www.texmed.org/Template.aspx?id=6871>. Accessed April 4, 2017.

⁶ Health Resources and Services Administration website. <https://bhwh.hrsa.gov/shortage-designation/hpsa-process>. Accessed January 11, 2017.

⁷ Health Resources and Services Administration. <https://www.hrsa.gov/advisorycommittees/shortage/Meetings/20100922/currentcriteria.pdf>. Accessed April 4, 2017.

⁸ VAOIG. *Alleged Staffing, Quality of Care, and Administrative Deficiencies*, Amarillo VA Health Care System, Amarillo, Texas, (Report No. 14-03822-289, July 6, 2017).

2. The Childress CBOC had inadequate space to provide patient care and privacy for veterans and staff, and to store medical equipment. Additionally, the CBOC did not meet Veterans Health Administration (VHA) environment of care requirements for the provision of care to women veterans.
3. The Childress CBOC did not provide the same level of care as provided at the facility.
4. The Childress CBOC Registered Nurses and Licensed Vocational Nurses did clerical work such as answering the telephone, scanning, faxing and scheduling patient appointments because the facility did not assign clerical staff.
5. Childress CBOC nurses lacked supervisory oversight from the facility and may have been doing triage which is out of their scopes of practice.
6. Lubbock CBOC staff were not trained in scheduling patient appointments.
7. Lubbock CBOC staff destroyed records, kept paper lists, and changed dates when patients wanted to be seen.

While on site, we received complaints that the Childress CBOC lacked supplies for rapid testing and vaccination that were available at other primary care clinics. We reviewed these complaints in association with allegation #3.

Scope and Methodology

We initiated our review in July 2014 and completed our work in February 2016 with updates regarding vaccination shortages in April 2017. We conducted site visits August 4–8, and August 18–22, 2014; January 20–23, 2015; and March 23, 2016.

We interviewed the former Director (August 2014), the Acting Director (January 2015), the Chief Nurse Executive (CNE), Chief of Staff (COS), Chief of Medicine, the CBOC nurse manager, the CBOC Coordinator/Ambulatory Administrative Assistant to the COS, and the Lubbock CBOC Director. We conducted interviews with managers, providers and other clinical and administrative staff knowledgeable about CBOC patient appointment scheduling, patient care, and other quality issues.

We reviewed VHA and facility policies, provider panel data, next available appointment data, and information regarding Clovis, Childress, Dalhart, and Lubbock communities and healthcare access.

In August 2014, we conducted an unannounced inspection of the Childress CBOC and scheduled inspections of the other three CBOCs. While at the CBOCs, we interviewed more than 55 employees.

In November 2014, we reviewed 359 electronic health records (EHR) of Clovis CBOC patients who had not been seen by a CBOC PCP since November 27, 2012. We

reviewed 180 Childress patients who had not been seen by a CBOC PCP since December 31, 2013.

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts show the allegations are unfounded. We **cannot substantiate** allegations when there is no conclusive evidence to either sustain or refute the allegation.

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: Lack of Follow-Up for Enrolled Veterans

We substantiated that 359 Clovis patients and 180 Childress patients had not been seen by a PCP for over 1 year. However, we did not find a requirement that patients be seen yearly. Frequency of follow-up visits should be determined by the provider and patient and varies with individual patients based on comorbidities, medical history, age, prescribed therapies, and patient/provider preference.

Clovis CBOC

In April 2012, the Clovis CBOC had two permanently assigned PCPs to care for approximately 1700 enrolled veterans. One of the PCPs left the facility in April 2012; the second PCP left in July 2013, leaving the facility with no permanently assigned PCP. PCPs from other facility locations were temporarily assigned to the CBOC, or patients were assessed via Clinical Video Telehealth (CVT)⁹ 2 days per week. In November 2013, the facility assigned a PCP to see patients at the CBOC 3 days a week until a permanent PCP was hired in February 2014. In April 2014, a second PCP was hired.

When a PCP was not on site at the CBOC, patients requesting care were referred to the CBOC nurse who would explain that a PCP was not available, and offer a future appointment when a PCP was available. The nurse would also inform the patient that care was available at the Lubbock CBOC or the facility. If urgent care was needed, patients were referred to a local Emergency Department or their private PCP if they had one.

We requested lists of patients enrolled at the CBOC for the timeframe that a permanent PCP was not assigned. We reviewed the EHRs of patients who had not been seen at the CBOC for 1 year or longer. Of the 359 patients' EHRs we reviewed, we concluded that 3 patients may have been adversely impacted by the lack of follow-up at the Clovis CBOC. For these three patients, we obtained and reviewed pertinent non-VA medical records as well as the VHA EHRs; their care is detailed below:

Clovis Case Summaries

Patient 1: At the time of his death in 2013, the patient was a male in his eighties with a past medical history that included hypertension, an elevated prostate specific antigen (PSA), enlarged prostate, chronic prostatitis, chronic kidney disease, and depression.

⁹ "Clinical Video Telehealth (CVT) is defined as the use of real-time interactive video conferencing, sometimes with supportive peripheral technologies, to assess, treat, and provide care to a patient remotely." VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014. CVT is a means by which staff can use on screen viewing to see and communicate with patients who are located in a remote location.

He received care for his chronic prostatitis through a non-VA urologist. The patient did not want to pursue further specialty evaluation of his elevated PSA and enlarged prostate.

In 2012, the patient had a routine appointment with his PCP at the CBOC. The PCP reviewed the patient's blood pressure and recent laboratory results. He noted the blood pressure was controlled and renewed the patient's medications.

Entries in the patient's VA EHR after the 2012 evaluation by the PCP include multiple notes from the CBOC nursing staff regarding medication renewals and refills but no PCP assessment notes.

According to an interview with a family member, beginning in 2013, she had difficulty scheduling the patient's annual VA medical visit. She reported to us that she made multiple calls to the CBOC and the CBOC nurse told her that the clinic did not have a PCP. She frequently spoke with the nurse to request medication renewals, but the patient was not evaluated by a PCP prior to his death in 2013. The patient had a scheduled appointment approximately one month prior to his death; however, that appointment was "cancelled by clinic".

Two days prior to the scheduled appointment that was cancelled, the family member went to the patient's home and found him "slouched over his kitchen table" speaking incoherently. Emergency Medical Service was called and he was taken to a non-VA hospital and transported by helicopter to a trauma center.

According to non-VA records we reviewed, physicians at the trauma center diagnosed the patient with obstructive uropathy¹⁰ and chronic hygromas.¹¹ A computerized tomography (CT) scan of his brain suggested that the hygromas had enlarged slightly when compared to a 2008 CT scan. The attending physician documented that the mental status changes were likely a metabolic effect related to the uropathy. A consulting neurosurgeon documented that the left-sided hygroma was causing an increase in intracranial pressure. After several meetings, the medical team and family decided that the patient would not tolerate a procedure to relieve the intracranial pressure, so a referral to hospice was initiated. The patient was transferred to hospice care and died approximately 2 weeks later.

This elderly male patient had known kidney disease and an enlarged prostate. Routine laboratory work and symptom assessment between the 2012 PCP assessment at the CBOC and his admission to the trauma center in 2013 would have been important to monitor the patient's response to and compliance with his prescribed medications as well as the safe metabolism of those medications in light of his age and renal function.

¹⁰ Obstructive uropathy occurs when urine cannot drain through a ureter (a tube that carries urine from the kidneys to the bladder).

¹¹ Hygroma is also known as a chronic subdural hematoma or "old collection of blood and blood breakdown products between the surface of the brain and its outermost covering (the dura)."

<https://medlineplus.gov/ency/article/000781.htm>. Accessed January 11, 2017.

Scheduled follow-up with his PCP could have prevented this patient's progression to complete obstructive uropathy.

Patient 2: At the time of his death in 2013, the patient was in his eighties with a past medical history that included hypertension, emphysema, and chronic kidney disease. He received primary care at the CBOC from 1998 until his death in 2013.

In 2011, the patient had a routine appointment with his PCP. The patient had no complaints, his vital signs were stable, and his medications were renewed. In 2012, the patient's PCP left the CBOC.

The patient called the CBOC requesting a medication refill in 2013. He spoke to a nurse who documented in his EHR that the patient requested refills and complained that he was "having a hard time breathing." The nurse's note does not include documentation that the patient was instructed to seek urgent care or that the nurse discussed his symptoms with a physician.

According to an interview with a family member who tried multiple times to get an appointment scheduled for the patient, he was repeatedly told "there were no PCPs available." Approximately 3 weeks after the call to the CBOC for the medication refill, the patient went to a non-VA Emergency Department complaining of shortness of breath; he was admitted and treated for pneumonia. He improved and was transferred to a nursing home for rehabilitation. He stayed for about a month and was transferred to another nursing home closer to his family. Approximately 2 weeks later, he was admitted to a non-VA facility with diarrhea and dehydration. He was diagnosed with a large pulmonary effusion and multiple liver lesions. He refused further treatment, was admitted to hospice, and died 5 days later.

The patient was an elderly male with multiple chronic conditions who reported to the CBOC nurse in 2013 that he was experiencing shortness of breath. The EHR contained no documentation that he was directed to seek immediate care, or that the nurse discussed the patient's symptoms with a provider. A more timely assessment and management of this patient's symptoms may have prevented the first hospital admission and need for rehabilitation.

Patient 3: At the time of his death in 2013, this patient was in his early 50s with a past medical history significant for coronary artery disease, diabetes mellitus, chronic obstructive pulmonary disease (COPD-emphysema), tobacco use, and an abdominal aortic aneurysm (AAA), which was repaired in 2011. He had been receiving care at the Clovis CBOC since 2009 and was seen regularly until late 2012.

During the late 2012 appointment, the PCP reviewed the patient's vital signs (which were stable) and laboratory results. The patient's oxygenation was low; the provider ordered pulmonary function studies and encouraged the patient to quit smoking cigarettes. The PCP adjusted the patient's cholesterol medication and discontinued one blood pressure medication. The PCP noted in the VA EHR that although the patient had hypertension that "had been difficult to control," she would remove one blood pressure medication and based on the patient's response to the removal of that

one medication, would adjust the remaining medication as needed. The patient also had some complications with wound healing at the site of his AAA repair surgical scar. The PCP recommended a solution to clean that area. The PCP did not document plans for follow-up on the blood pressure management modification, the patient's emphysema symptoms, or the abdominal wound.

The pulmonary function studies were completed at a non-VA facility within the next 30 days and indicated that the patient had "early emphysema." In mid-2013, he was seen at the facility for treatment of a minor dermatologic condition. At that appointment, his vital signs were within normal limits.

Approximately one month after the dermatology assessment at the facility, the patient had laboratory tests in preparation for a previously scheduled CBOC primary care appointment. The patient's cholesterol was elevated from previous tests and his blood sugars (as evaluated by an HgA1C¹² and glucose) were elevated. The appointment was "cancelled by clinic" the day after the laboratory tests and one week before the appointment. We did not find evidence in the EHR that the patient was notified of the laboratory tests or that he was contacted to reschedule his cancelled appointment.

Approximately 3 months later, a nurse at the CBOC documented that the patient called requesting refills of three of his medications. Two weeks later, the COS at the facility renewed the medications after signing the nurse's telephone encounter, which included documentation of the patient's cholesterol and blood sugar laboratory results. We did not find evidence during this time frame in the EHR that the patient was contacted regarding his laboratory results.

The patient died at home approximately one month after renewal of his medications. Per the patient's death certificate, the immediate cause of death was congestive heart failure related to coronary artery disease and AAA.

This patient had multiple chronic conditions that warranted routine monitoring. At his last clinic appointment approximately one year prior to his death, the patient was noted to have a low oxygenation level. The provider adjusted medications used to control his blood pressure and cholesterol, but we did not find evidence that a provider reviewed test results or assessed the patient's response to the medication changes. We did not find documentation of a re-evaluation of the patient's wound that was discussed at the late 2012 appointment. Although his vital signs and oxygenation were checked during a 2013 dermatology appointment, follow-up with the PCP was inconsistent and fragmented. Consistent follow-up may have offered opportunities for providers to manage the patient's congestive heart failure related to his coronary disease.

¹² Hemoglobin A1C is a blood test that measures a patient's average blood glucose for the preceding 3 months.

Childress CBOC

Recruitment for a Childress CBOC PCP was initiated in January 2010, and the facility opened the CBOC in October 2011 without a permanently assigned PCP to see the approximately 455 patients. A facility PCP traveled to the CBOC 2 days a week to provide patient care. The CBOC had a permanently assigned PCP from June 25, 2012 through November 2013 who resigned, leaving the CBOC with no permanently assigned PCP. From November 2013 through November 18, 2014, a facility PCP went to the CBOC one day per week. In February 2014, the facility hired a part-time PCP, who saw an average of five patients a day, 2 to 3 days per week.

We requested lists of patients enrolled at the CBOC for the timeframe that a permanent PCP was not assigned. We reviewed the EHRs of patients who had not been seen at the CBOC for one year or longer. Of the 180 patients' EHRs we reviewed, we concluded that no patients were adversely impacted by the lack of follow-up at the Childress CBOC.

Issue 2: Childress CBOC Space and Provision of Care Concerns

Inadequate Space to Provide Patient Care, Maintain Privacy, or Store Equipment

Patient Care

We did not substantiate that space at the Childress CBOC was inadequate for staff to provide patient care. However, we determined that CBOC space was limited.

The Childress CBOC occupies space in a non-VA healthcare facility. During our August 2014 and January 2015 site visits, we observed patients entering the front door of the non-VA clinic and going to a kiosk in a shared non-VA and VA waiting room to sign in for their appointments. CBOC staff told us that once the patient completed the sign-in process via the kiosk, a message was sent to a VA clinic computer alerting them that a patient was in the waiting room. If VA patients had been waiting for a while, or did not understand how to use the kiosk to sign in, they would approach the non-VA facility's desk and ask non-VA staff to call the VA CBOC staff. The VA CBOC staff would come and escort patients back to the VA clinic space.

We observed during our August 2014 site visit that the CBOC had three rooms with doors: one exam room, the RN/LVN office, and a small room the LVNs used for making phone calls to patients and various other administrative duties. In addition, a blood drawing chair and a small narrow counter used for the laboratory processing equipment were located in a small alcove. The RN/LVN office contained two desks, the CVT equipment, copier, medication refrigerator, and a small closet for patient supplies. The RN/LVN office also served as the CVT center and was used for RN/LVN administrative duties and patient education. When used for CVT appointments, it could not be used for patient education or other administrative duties. Staff told us that they were frequently interrupted during CVT sessions with a patient. However, during two of our site visits, we observed no more than three patients in the clinic at any one time and we concluded that based on the number of patients, the space was adequate.

Privacy

We did not substantiate that space was inadequate to provide privacy for the patients and staff. We observed that when staff were with patients behind closed doors, staff used white noise machines to help maintain auditory privacy.¹³ Conversations could occasionally be heard in the hallway outside of the room if the white noise machine was not in use.

Equipment Storage

We substantiated that the Childress CBOC did not have a dedicated area to store medical equipment but determined that it did not interfere with provision of care.

During our August 2014 and March 2016 site visits, we observed that the clinic had very limited storage space. The RN/LVN office housed the copier, the medication refrigerator, employee refrigerator, a small closet with medical supplies, and the CVT equipment. The blood drawing alcove had extremely limited space for the laboratory processing equipment. Although the space was small, it was well organized and adequate for the function of the clinic.

Provision of Care

Primary Care/Supplies

We did not substantiate that the Childress CBOC did not provide comprehensive primary care. We determined that rapid testing supplies and/or equipment was not available due to space issues and that the CBOC had experienced intermittent shortages of Tetanus, Diphtheria, Pertussis (Tdap) vaccine in 2015 and 2016, but the shortage issue was resolved in 2017.

VHA Handbook 1101.10 requires that comprehensive primary care be provided either by the Patient Aligned Care Team (PACT) or arranged to be provided by others.¹⁴ The CBOC provides the same level of basic primary care and mental health via CVT as the facility. Laboratory testing analysis, radiology, and specialty care are not provided at the CBOC. If a PCP deems these services necessary, patients are referred to the facility or non-VA care. Rapid testing for the flu,¹⁵ strep throat,¹⁶ or a urinalysis was not available as the CBOC did not have the machinery to complete the rapid testing.

Staff also reported frequent shortages of the Tetanus, Diphtheria, Pertussis (Tdap) vaccine. During our site visits in January 2015 and March 2016, we confirmed that the

¹³ White noise machines emit a consistent, soothing soundtrack.

¹⁴ VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014. The Patient Aligned Care Team is a team of health care professionals that provides comprehensive primary care in partnership with the patient and the patient's support person(s).

¹⁵ Rapid influenza diagnostic tests are screening tests for influenza virus infection.

¹⁶ Rapid strep diagnostic tests are screening tests for Streptococcus Pyrogens bacteria which causes strep throat.

CBOC had shortages. Staff informed us that if the Tdap vaccine was indicated but not available, the patient would be referred to the local medical clinic or another VA facility.

In April 2016, we contacted the Facility Director, COS, and the Chief Nurse Executive to discuss the lack of rapid laboratory testing supplies as well as the reported frequent shortage of the Tdap vaccine. They told us they were unaware of the shortage of the Tdap vaccine but would address that immediately. In April 2017, we contacted facility leadership and they informed us that the Childress CBOC has the Tdap vaccine. Facility leadership informed us that because of significant space shortages at the Childress CBOC, space was not available for rapid testing analyzer equipment. However, if these tests were deemed necessary by the PCP, “the patient is referred to the Amarillo or Lubbock facilities or sent to the non-VA medical center for testing.”

Women Veterans

We did not substantiate that the Childress CBOC did not meet the VHA environment of care requirements for the provision of care to women veterans.

VHA policy outlines criteria for the care of women veterans seen in a gender neutral primary care clinic.¹⁷ The handbook requires, and we observed, that the exam room be equipped with privacy curtains that shielded the examination table should the door be opened during an exam. In addition, the door to the exam room could be locked for privacy, and a unisex restroom was located immediately outside the exam room.

Clerical Duties

We substantiated that clerical staff were not assigned to the CBOC and that LVNs performed clerical duties. However, VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook*,¹⁸ states that the PACT may be configured with team members who have different, designated roles to meet the needs of the patient population. A facility manager told us that staffing the clinic with two LVNs rather than clerical staff was preferred as that configuration would allow increased flexibility with cross coverage of clinical and clerical responsibilities.

¹⁷ VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010. This VHA Handbook was in effect at the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1330.01, *Health Care Services for Women Veterans*, February 15, 2017. The 2017 Directive states that “[e]ach VA medical facility must ensure that eligible women Veterans have access to high-quality, equitable, comprehensive medical care...that provides privacy, dignity and security.”

¹⁸ VHA Handbook 1101.10 *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014.

Issue 3: Childress CBOC Supervisory Nursing Oversight and LVN Triage

Supervisory Oversight

We did not substantiate that CBOC nursing staff lacked supervisory nursing oversight. Additionally, we did not find a VHA or facility policy that required on-site nursing supervision.

During our site visit in August 2014, we received inconsistent information regarding whether the PACT nursing supervisor or the Primary Care Nursing supervisor visited the Childress CBOC. The CBOC staff stated that the PACT nursing supervisor was not on site but he/she was very responsive via telephone and e-mail. They also stated that the Chief Nurse Executive made rounds with the EOC group at the CBOC. In addition, the Administrator to the Chief of Staff/CBOC Coordinator visited the CBOC frequently, and assisted the CBOC with questions and supply requests.

LVN Triage

We substantiated that the LVNs may have been performing triage,¹⁹ which is outside of their scope of practice.

During our January 2015 visit, we spoke with the PCP and the two LVNs. The PCP voiced concerns to us regarding the training and supervision of the nursing staff and stated that the LVNs may have been doing triage which was out of their scope of practice.

The LVNs we interviewed voiced concerns regarding the management of patients when an RN or PCP were not available. Patients presenting for care at the CBOC during times of RN/PCP non-availability, would sign in to the kiosk in the non-VA waiting area until a VA CBOC LVN came to the non-VA waiting room to speak with them. If an LVN did not see the computer message that a patient was waiting, the patient could wait a long while. Once an LVN came to the waiting room, he/she would do a brief assessment to determine what the patient needed. He/she would then inform the patient that no PCP or RN was available and that the patient would need to seek care at the facility, his/her local provider (if the patient had a non-VA provider), or go to a local Emergency Department. The LVNs would also offer to schedule a future appointment. If the patient needed medications renewed, the LVN would contact a facility PCP to facilitate the patient receiving the medications.

The Texas State Board of Nursing states that “LVNs are not educationally prepared to perform triage assessments, either telephonically or in the role of the health care professional initially assessing a client to determine treatment priorities in any setting.”

¹⁹ Triage is the sorting of patients and prioritizing of care based on the degree of urgency and complexity of patient conditions.

The LVNs told us they had repeatedly communicated their concerns about the lack of availability of an RN or PCP in the CBOC to PACT nursing supervisors and asked for a site visit so that the supervisor could observe the clinic work flow. At the end of January 2015, the PACT nursing supervisor made a 3-day site visit. In February, the Interim Director sent an email to the CBOC nursing supervisor outlining processes to follow when a patient presented for care during times when no RN or PCP was at the CBOC and a patient presented at the CBOC for care. In addition, the email contained the PACT LVN responsibilities. The email was forwarded to the LVNs at the Childress CBOC.

The CBOC was without RN coverage for approximately 5 months from December 2014 to May 2015. During that time, the PCP would occasionally have the LVNs do some tasks normally completed by the RN, such as post discharge phone calls to answer any questions a patient had regarding discharge instructions. On March 20, 2015, we conducted a conference call with the former Director and COS to voice concerns that LVNs at the Childress CBOC may have been triaging patients, which was not in their scope of practice. The Director informed us that a new process was instituted on March 2, 2015 whereby Childress LVNs were instructed to call the Amarillo facility nurse advice line and hand the phone to the patient so that the patient could discuss any concerns with the facility advice-line RN. We followed up with CBOC staff who stated the new process was an improvement.

Issue 4: Lack of Patient Scheduler Training and Destruction of Paper Wait Lists at the Lubbock VA Outpatient Clinic

Training

We did not substantiate the allegations that Lubbock OPC staff lacked training in scheduling or kept paper wait lists. We reviewed 18 Lubbock staff training records regarding scheduling patient appointments and found that all 18 had completed the training. We also interviewed the 18 staff regarding the training they received. Three of 18 had not completed the 1:1 training with the scheduler supervisor. We asked the schedulers if they were aware of destruction of paper wait lists. None of the 18 had any knowledge of paper wait lists or that wait lists were destroyed.

Destruction/Paper Wait Lists

On March 8, 2016, we published the report, *Administrative Summary of Investigation by the VA Office of Inspector General in Response to Allegations Regarding Patient Wait Times, Endoscopy Clinic Amarillo at the VA Medical Center Texas Outpatient Clinic Lubbock at the VA Medical Center, Texas*, (Report No. 14-02890-152). The report stated the allegations were:

The Outpatient Clinic (OPC) Lubbock has been shredding papers and changing documentation as to the requested date patients asked to be seen. They are doing this at the request of their managers. It was reported that they do have a paper list that veterans are placed on. Once a slot opened up, they were then put on the "real" list and it appears that they were only on a waiting list for 25 to 35 days when, in fact, they have

been waiting for more than 150 days. Staff reported they were never trained in patient scheduling. They do not use the electronic scheduling system because no one ever trained them. They report a severe shortage of registered nurses and providers, which has caused huge backlogs in veterans' care. Lack of training and lack of access to documentation was reported. There were reports that employees were told by their managers to change the desired dates of veterans to a date that would reflect shorter patient wait time

The report concluded that:

For the 10 employees reviewed from the Lubbock OPC, all 10 employees were required to "Accurately schedule appointments according to the VHA Directive ([2003-062], corrected)."²⁰

- The FY 2014 Performance Evaluations for the employees interviewed at OPC Lubbock disclosed the Performance Elements/Standards on most employees Performance Appraisal Program forms contained the wording, "Scheduling Procedures: Critical Element: Demonstrates proper scheduling techniques by following current established directives, policies and associated performance measures. This includes appropriate use of desired date, EWL [Electronic Wait List], Recall Clinics, consult management and patient eligibility."*
- Data related to appointment scheduling, specifically the period of time between the desired date and the appointment date, for appointments occurring in the second and third quarter of FY 2014 for OPC Lubbock, was obtained from VHA. The data were analyzed by the VA OIG Data Management Division and divided into individual reports reflecting: percentage of scheduled appointments for which the desired date was equal to the appointment date; percentage of scheduled appointments for which the scheduled date was within 7 days of the desired date; and percentage of scheduled appointments for which the scheduled date was within 14 days of the desired date. The data reflect that an average 94.5 percent of all scheduled appointments were reported as scheduled within the 14-day period of the veteran's desired date.*
- At the OPC Lubbock, only one employee reported that the clinic's practice had been to use the next available date as the desired date, which he believed to be due to the instructions of a former supervisor. He reported this practice was discontinued after all the recent media coverage regarding patient wait time manipulation at VA. Interviews with other OPC Lubbock employees did not provide support for the allegations of manipulation of patient wait times or the destruction of patient paper lists.*

Conclusions

We substantiated that from November 2012 to November 2014, the Clovis and Childress CBOCs had greater than 100 patients who had not been seen for more than one year by a primary care provider, and that 3 patients may have been adversely impacted by a lack of follow-up care at the Clovis CBOC. However, we did not find a

²⁰ This Directive was rescinded June 9, 2010, and replaced with VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010, which was also rescinded and replaced with VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, June 15, 2016. The 2016 Directive uses the terms clinically indicated or preferred date rather than "desired date".

requirement that patients be seen yearly. Frequency of follow-up visits should be determined by the provider and patient and varies with individual patients based on comorbidities, medical history, age, prescribed therapies, and patient/provider preference. We identified 3 patients who may have been adversely affected by waiting more than one year for follow-up.

We did not substantiate that in March 2016, the Childress CBOC had inadequate space to provide patient care and ensure privacy for staff and veterans. We found that staff were able to provide patient care and ensured auditory privacy for veterans and staff by using white noise machines. We substantiated that the Childress CBOC did not have a dedicated area to store medical equipment, but determined that it did not interfere with provision of care.

We did not substantiate that in January 2015, Childress staff could not provide comprehensive care or the same level of primary care to patients at the CBOC as provided at the facility. Services that were not available on-site were offered via other mechanisms such as telehealth or referrals. We determined that rapid testing supplies and/or equipment were not available due to space issues and that the CBOC had experienced shortages of Tetanus, Diphtheria, Pertussis (Tdap) vaccine in 2015 and 2016, but the shortage issue was resolved in 2017. When laboratory tests, radiology tests, specialty care, or vaccinations were required and not available at the CBOC, the Childress CBOC PCP referred patients to the facility or to the local non-VA facility.

We did not substantiate that in January 2015, Childress CBOC failed to meet VHA environment of care requirements for the provision of care of women veterans. We observed that the exam room was equipped with privacy curtains, which shielded the examination table should the door be opened during an exam. In addition, the door to the exam room could be locked for privacy and a unisex restroom was located immediately outside the exam room.

We substantiated that in January 2015, RNs and LVNs performed clerical duties because the facility did not assign clerical staff to the CBOCs. However, it was not a violation of VHA policy and allowed for cross coverage of clinical and clerical duties.

We did not substantiate that in January 2015, the clinic lacked supervisory nursing oversight. We could not find a VHA or facility policy that required on-site nursing supervision at the CBOCs. Although nursing supervisors made infrequent visits to the clinic, nursing staff were supervised and were able to contact supervisors by phone and email. We found LVNs may have exceeded their scope of practice when an RN or PCP was not available at the clinic. A new process was instituted to provide patients access to an RN and/or a PCP by phone when an RN or PCP was not available at the CBOC.

We did not substantiate that in August 2014, Lubbock CBOC staff lacked training in scheduling patient appointments. We found that all Lubbock scheduling staff had completed the required scheduling training.

We did not substantiate that in August 2014, Lubbock staff destroyed documents or kept paper wait lists at the time of our site visits. We interviewed 18 schedulers and

determined that they were not aware of destruction of documents or the use of paper wait lists. In response to similar allegations, VAOIG Office of Investigations issued an *Administrative Summary of Investigation* report in March 2016 that did not support manipulation of data or destruction of paper wait lists by Lubbock CBOC staff.²¹

Recommendations

1. We recommended that the Amarillo VA Health Care System Director ensure that community based outpatient clinics are appropriately staffed to provide care.
2. We recommended that the Amarillo VA Health Care System Director ensure that managers conduct clinical reviews of the three Clovis Community Based Outpatient Clinic patients discussed in this report to determine whether a delay in follow-up adversely affected their outcomes and take action as appropriate.

²¹ VAOIG Office of Investigations. *Administrative Summary of Investigation by the VA Office of Inspector General in Response to Allegations Regarding Patient Wait Times, Endoscopy Clinic Amarillo at the VA Medical Center Texas Outpatient Clinic Lubbock at the VA Medical Center, Texas, (Report No. 14-02890-152, March 8, 2016).*

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: June 29, 2017

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

Subj: Healthcare Inspection—Alleged Provision of Care, Nursing Supervision, and Scheduling Issues at Community Based Outpatient Clinics at the Amarillo VA Health Care System, Amarillo, Texas

To: Director, Washington, DC Office of Healthcare Inspections (54DC)
Director, Management Review Service (VHA 10E1D MRS Action)

1. Thank you for the opportunity to review and respond to the report, Healthcare Inspection – Alleged Provision of Care, Nursing Supervision, and Scheduling Issues at Community Based Outpatient Clinics at the Amarillo VA Health Care System, Amarillo, Texas.
2. I have reviewed and concur with the recommendations in the report. If you have any questions or require further information, please contact Denise B. Elliott, Quality Management Officer for VISN 17 at 817-385-3734.

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Jeff Milligan
VISN 17 Network Director

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: June 12, 2017

From: Director, Amarillo VA Health Care System (504/00)

Subj: Healthcare Inspection — Alleged Provision of Care, Nursing Supervision, and Scheduling Issues at Community Based Outpatient Clinics at the Amarillo VA Health Care System, Amarillo, Texas

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

1. Attached you will find the facility response to Recommendations 1 and 2 for the OIG report entitled “Alleged Provision of Care, Nursing Supervision, and Scheduling Issues, Amarillo HCS CBOCs, Amarillo, TX.” I have reviewed the findings, the recommendations, and the action plan and concur.
2. Should you have any questions, please contact Jinjer Mitchell, Acting Chief, Quality, Safety, Value Service at (806)355-9703 ext. 7772.

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Michael Kiefer, MHA, FACHE
Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Amarillo VA Health Care System Director ensure that community based outpatient clinics are appropriately staffed to provide care

Concur

Target date for completion: September 30, 2017

Facility response: In order to ensure patient safety and follow-up, the following has been put into place when providers are not available for the CBOCs in the rural communities:

- A physician coverage schedule utilizing physicians from Amarillo is implemented to handle the day-to-day items, such as prescription refills
- Nursing staff in the rural CBOCs are given access and keys to schedule any of their patients in Amarillo to be seen promptly if they choose
- Patients are offered appointments through the Choice program, if they do not want to travel to Amarillo
- Utilize CVT appointments when staffing allows and Veterans consent

The Amarillo VAHCS is in process of transitioning all Nurse Practitioners to full practice authority. Nurse Practitioners will then be licensed independent practitioners which will provide additional resources for rural community staffing.

Additionally, the National Physician Recruiter is providing additional funding so that our facility can post vacant provider positions in journals and local newspapers.

Recommendation 2. We recommended that the Amarillo VA Health Care System Director ensure that managers conduct clinical reviews of the three Clovis Community Based Outpatient Clinic patients discussed in this report to determine whether a delay in follow-up adversely affected their outcomes and take action as appropriate.

Concur

Target date for completion: 07/31/2017

Facility response: A thorough clinical review was completed by the Chief of Staff of the three Clovis CBOC patients discussed in the report. It was determined that there was no clear causal link between the causes of death and delay in follow-up care. However, in order to ensure that patients receive the proper level of care timely,

education will be provided face-to-face by the nurse managers and/or nurse educators to the CBOC nursing staff in the rural communities of Dalhart, Childress, and Clovis. Education will contain, but is not limited to, basic triage material, including identification of red flag symptoms that should prompt an urgent referral to an emergency room or urgent care center and documentation of the full details of the call.

OIG Contact and Staff Acknowledgments

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