# Department of Veterans Affairs
# Office of Inspector General

# Healthcare Inspection

# Alleged Imminent Danger to Patients
# Southern Arizona VA Health Care System
# Tucson, Arizona

**Report No. 10-01175-91** **February 16, 2011**

VA Office of Inspector General
Washington, DC 20420

**To Report Suspected Wrongdoing in VA Programs and Operations:**
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# Executive Summary

The Office of Inspector General received a complaint that alleged unsafe care and imminent danger to patients who receive care at the Primary Care Clinics at the Southern Arizona VA Health Care System in Tucson, Arizona (the facility). The allegations included unsafe triage and handoff of patients from the Emergency Department (ED), inadequate clinical support staff, unsafe patient panel sizes, and other quality of care issues.

We did not substantiate that patients in Primary Care (PC) were in imminent danger however we did identify opportunities for improvement in clinic operations. The facility had experienced significant turnover among Primary Care Providers (PCPs) that resulted in reassignment of patients to the remaining PCPs who felt overwhelmed with their panel sizes and unsupported by management. Also, there were limited treatment options for patients with chronic pain issues and care was often not coordinated. The facility met with the PCPs and acknowledged their concerns. The facility's Systems Redesign Committee has begun to undertake changes.

We substantiated that there was unsafe triage of patients in the ED. ED staff did not always evaluate every patient before discharge as required by policy. The facility utilized the Emergency Nurses Association's Emergency Severity Index (ESI) for triage. The ESI allows the triage nurse to judge how long patients can wait to be seen by a provider, with level 1 as the most urgent and level 5 the least. ED staff sometimes sent ESI 4 and 5 patients for a second screening in PC where they were given appointments to be seen by a provider at a later date.

We did not substantiate that patients received renewal of narcotic and non-narcotic prescriptions without proper assessment. However, we noted opportunities for organizational improvement in the care of patients with chronic pain. The facility has taken appropriate action to provide support to the PCPs by following the Patient Aligned Care Team (PACT) recommendations as well as the guidance provided by the VHA National Pain Management Strategy group.

We did not substantiate that clinical staff was inadequate in PC, that consultants were placing orders under the PCP's name without notification or consent of the provider, or that inadequate number of providers resulted in poor patient follow-up, unsafe patient panel sizes, unassigned patients, and practitioners being forced to work long hours and from home.

The VISN and facility Directors agreed with our findings and recommendations. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

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

**TO:** Director, VA Southwest Health Care Network (10N18)

**SUBJECT:** Healthcare Inspection– Alleged Imminent Danger to Patients, Southern Arizona VA Health Care System, Tucson, Arizona

## Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) received allegations of unsafe care and imminent danger to patients at the Southern Arizona VA Health Care System, Tucson, Arizona. The purpose of this investigation was to evaluate the merit of the allegations.

## Background

The Southern Arizona VA Health Care System, part of the VA Southwest Health Care Network (Veterans Integrated Service Network [VISN] 18), includes the Tucson VA Medical Center in Tucson, Arizona. The facility is a tertiary facility that provides a broad range of inpatient and outpatient health care services.

On December 10, 2009, a complainant contacted the OIG hotline with allegations of unsafe care and imminent danger to patients who receive care at the Primary Care clinics.

Specific allegations included the following:

- Unsafe handoff of patients from the Emergency Department.
- Unsafe triage of patients.
- Inadequate clinical support staff.
- Renewal of narcotic and non-narcotic prescriptions without appropriate patient assessment.
- Ordering tests under the providers name without notification or consent of the provider.
- Inadequate numbers of providers to allow for timely patient follow up.
- Unsafe patient panel sizes.
- Thousands of unassigned patients who do not have a provider.

- Practitioners forced to work long hours and work from home to keep up with the assigned work load.

## Scope and Methodology

We reviewed pertinent documents, including Veterans Health Administration and facility policies and procedures, The Joint Commission standards, committee meeting minutes, quality management documents, and medical records.

We conducted a site visit February 16-18, 2010, interviewing medical care professionals to gain further understanding of the issues. We interviewed the Chief of Staff (COS), the Chief of Primary Care, the Director of the Emergency Department, the Chief of the Pharmacy Care Line, the Pain Clinic Coordinator, the Chief of Information and Technology, and others knowledgeable about the issues.

For insights into critical interactions between the ED and PC clinic, we visited both departments and interviewed staff. We reviewed the records of patients seen by the ED triage nurse and referred to PC and examined the 364 notes for patient encounters entered by five PC triage nurses during October 15-19, 2009. Finally, we examined provider panel sizes, ancillary staffing levels, documentation about unassigned patients, and PCP notes for evidence of after-hours activity.

To assess the appropriateness of care for patients prescribed narcotics, we identified all outpatients prescribed oxycodone, hydrocodone, and morphine during February 2010. After accounting for the relative potency of each medication and for the number of pills dispensed, we identified the patients who had received the largest overall amounts of narcotics.[1] For each of these patients we examined medical records to evaluate comprehensiveness and coordination of care.

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

## Findings

### Issue 1. Imminent Danger to patients in Primary Care

We did not substantiate this allegation, but did identify opportunities for improvement in clinic operations.

PCPs expressed frustration with management's lack of response to concerns. For several years the facility had experienced significant turnover among PCPs, requiring that patients be reassigned to new providers. Because they frequently had to evaluate new

[1] Katz NP, et al. Managing Chronic Pain with Opioids in Primary Care. Newton, MA: Inflexxion, Inc.; 2007:59 (Appendix 15).

patients, PCPs reported feeling overwhelmed and unsupported by management, with what they described as unreasonable demands on their time.

Providers also expressed frustration with their inability to schedule return visits for their patients, many of whom required narcotics for chronic pain. There was no specialist physician in the Pain Management Clinic and patients referred for pain management consultations were often placed on a waiting list. For many patients, treatment options were limited, long-term patient-provider relationships were difficult to establish and maintain, and care was often not coordinated.

Providers stated that multiple attempts to address concerns with management were unsuccessful. In December 2009, several PCPs signed a statement declaring that in their professional opinion patient care provided by the facility was unsafe and that a condition of imminent danger existed.

> We the undersigned Primary Care providers at the Southern Arizona VA Health Care System, Tucson, Arizona, hereby declare that a condition of Imminent Danger exists in the treatment and delivery of care to patients treated in Primary Care at the Tucson, VA. We declare that a danger exists which could reasonably be expected to cause death or serious physical harm immediately or before the imminence of such danger can be eliminated through normal procedures.

By the time of our site visit in February 2010, the facility had met with PCPs and acknowledged their concerns, and a Systems Redesign Committee had begun to undertake changes. Senior management confirmed an understanding of the challenges inherent in recruiting and retaining PCPs, and expressed a commitment to ensuring open communication and necessary support.

Although we made exhaustive inquiries to discover any examples of imminent danger to patients, we found no evidence to support this allegation. We considered management's actions to address the identified issues to be appropriate.

## Issue 2. Unsafe triage of patients in the Emergency Department

We substantiated this allegation.

We interviewed staff in the ED and in PC to understand processes for the care of unscheduled patients presenting to the facility. Patients may seek unscheduled access through the ED, PC Clinics, and the Urgent Care Clinic.

In the process of evaluating the relationship between ED and PC, we discovered that the ED was using an accepted triage system, but was applying it incorrectly.

VHA requires RN triage in all EDs consistent with an Emergency Nurses Association position statement dated July 1996, which entails the use of the Emergency Severity Index (ESI) for triage. [2] The ESI triage algorithm yields rapid, reproducible, and clinically relevant stratification of patients into five groups. The ESI triage system identifies patients with complex problems (ESI 1-2) and allows the triage nurse to judge how long patients can wait to be seen by a provider. Resource prediction is an integral part of the ESI level 3, 4, or 5 and is used to determine resources needed to make a disposition for the patient. Interventions considered to be resources for the purpose of ESI triage are those that go beyond physical examination or brief intervention by ED staff. Resources that require significant ED staff time (such as intravenous medication administration or chest tube insertion) and those that require staff or resources outside the ED (such as specialty consultations and x-rays) increase the patient's ED length of stay.

Resource prediction is of particular relevance for lower-acuity patients, who are typically judged to be ESI levels 4 or 5. These patients may require only limited attention by professional staff. However, according to policy, the ED must never discharge a patient before a medical assessment has been performed, in accordance with the provisions of title CFR 489.24, 489.20.[3]

At the facility, ESI 4 and 5 patients were sometimes sent for a second screening in PC. This second screening employed the Briggs triage system, an approach developed for telephone advice, with recommendations to patients about when to seek medical attention.[4] A key difference between ESI and Briggs is that the latter allows for care to be provided on a subsequent day, depending on patient symptoms. In contrast, the ESI assumes that the patient will be seen by an ED or Urgent Care provider during the same visit.

One ED nurse reportedly told patients that they would be waiting a long time to be seen, and that patients decided if they wanted to wait or not; however, we found no documentation of these interactions and none was provided. Likewise, we found no evidence that patients presenting to the ED were advised to wait for an evaluation before being given an appointment for a PC clinic visit on a subsequent day. At the time of our visit this issue was being examined by the facility's Systems Redesign Committee.

In the course of this inspection, we noted that the Urgent Care Clinic, which is located in the PC clinic and is staffed by a Nurse Practitioner (NP) with no assigned panel of patients, did not meet VHA policy criteria for designation as an Urgent Care Clinic.[5]

[2] VHA Handbook 1101.05, *Emergency Medicine Handbook*, May 12, 2010.
[3] *Emergency Medical Treatment and Labor Act*, The Center for Medicare/Medicaid.
[4] *Telephone Triage Protocols for Nurses*, 3rd Edition, Julie K. Briggs, Lippincott 2002.
[5] Directive 2007-043, *Standards for Nomenclature and Operations for Urgent Care Clinics in VHA Facilities*, December 18, 2007.

## Issue 3. Inadequate clinical support staff

We did not substantiate that there was inadequate clinical support staff in the primary care clinics. Staffing levels were consistent with national guidelines. Staffing is determined by the use of support staff ratio which is the number of full time employee (FTE) staff present in the clinic area assisting providers with delivery of PC per 1.0 FTE provider.[6]

Physicians, NPs and physician assistants (PAs) comprise the range of clinicians who provide comprehensive primary care to a panel of assigned patients.[7] We interviewed all types of PCPs, including those working at the facility for years as well as providers who were new in January 2010.

Providers who had recently worked outside VA did not agree that the clinics were understaffed. However, NPs expressed frustration with how they were treated by support staff, reporting that nurses would sometimes only assist physicians. Several NPs also stated that support staff was not being effectively utilized. They believed that support staff could carry out more administrative tasks for providers, such as making follow-up phone calls to patients. Finally, medical providers expressed dissatisfaction with the functional layout of the PC clinics, indicating that patient flow was impeded by a lack of optimally configured space for patient assessment and examination.

Management, including the COS, Chief of PC Services, and the Associate Director, acknowledged that even if the numbers of support staff were sufficient, there might be ways to improve how staff function and minimizes administrative demands on PC providers.

## Issue 4. Renewal of narcotic and non-narcotic prescriptions without proper patient assessment.

We did not substantiate this allegation. However, we noted opportunities for organizational improvement in the care of patients with chronic pain.

Providers described having insufficient time and support to adequately assess patients requesting narcotics. Some providers voiced the need for all patients with chronic pain to be assigned to the Pain Management Team, which would prescribe and monitor all narcotics. Other providers stated an understanding that they were responsible for pain management for all their patients. The COS and Chief of PC Services confirmed that providers have ultimate authority for clinical decisions about whether to prescribe a

[6] VHA Handbook 1101.02, *Primary Care Management Module (PCMM),* April 21, 2009.
[7] VHA Handbook 1101.02, *Primary Care Management Module (PCMM*), April 21, 2009

medication, acknowledging that some clinicians are more comfortable than others with the requirements of patients with complex medical problems and chronic pain.

Our review of the care provided for the patients with the 20 largest prescriptions for selected narcotics during February 2010 revealed no evidence that narcotics were being prescribed without adequate assessments. The 17 men and 3 women whose care was reviewed had a median age of 57 (range, 36-67). Fourteen of these patients had chronic low back pain and the remainder had other musculoskeletal problems. Fifteen of the patients had been evaluated by pain management consultants. Three patients, two of whom had not been evaluated by pain consultants, had received narcotics prescriptions from more than three different providers during the previous year.

VHA has promulgated two approaches pertinent to the management of chronic pain by PCPs. The PACT (Patient Aligned Care Team) model is a patient-driven, team-based approach for delivering efficient, comprehensive, and continuous care.[8] One of the goals of the PACT Model is to facilitate integration of chronic pain management seamlessly into PC practice sites. A second goal is to expand educational resources available to PC providers on management of chronic pain. A third goal is to initiate systems redesign projects to address controlled substance prescriptions written for chronic pain.

The VHA National Pain Management Strategy provides guidance to facilities for the use of a steppedcare model of pain management, with most pain care occurring in the PC setting.[9] This guidance calls for support for PCPs through access to consultations, diagnostic and rehabilitation services, education programs, collaboration with integrative mental health-PC teams, and post-deployment programs.

## Issue 5. Ordering of tests under a provider's name without notification or consent of the provider.

We did not substantiate that providers or nurses were ordering tests using PCP names without notification or consent. However, we did substantiate that consultants were placing orders for primary care patients with the expectation that PCPs would followup on test results.

Medical providers alleged that consultants expected PCPs to followup on the results of tests consultants had ordered for patients. Local parameters for the electronic medical record had been set so that PCPs received a notification anytime a test result became available for an assigned patient, with the understanding that PCPs were responsible for all actions in response to results. Non-PCP clinicians were not uniformly expected to followup on tests that they ordered. This arrangement created frustration among PCPs

[8] VHA Primary Care Program Office web site, accessed March 29, 2010.
[9] VHA Directive 2009-053, *Pain Management*, October 28, 2009.

and discord with specialists. We learned that PCPs had complained to management about the situation.

In response to these concerns, the Systems Redesign Committee had been created. At the time of our visit PCPs reported recent improvement. We were informed that all facility providers were reminded that the practitioner who places an order for testing is responsible for follow-up of results.[10]

## Issue 6. Inadequate number of providers resulting in poor patient follow-up, unsafe patient panel sizes, unassigned patients, and practitioners being forced to work long hours and from home.

We did not substantiate these allegations.

We found no evidence of inadequate PCP staffing, unsafe patient panel sizes, or an excessive number of unassigned patients.

Medical providers stated that the number of electronic clinical reminders (view alerts), that they received forced them to work long hours and work from home to keep up with the work load. A clinical reminder is a software decision support tool that can advise clinicians to perform certain tests or provide treatments appropriate for specific populations.

Our review of PCP progress notes revealed no indication that providers were routinely working outside of normal business hours.

## Recommendations

**Recommendation 1.** We recommend that the Director ensures that the facility employs the ESI triage system according to VHA policy.

**Recommendation 2.** We recommend that the Director ensures that patients who present to the facility's Emergency Department are evaluated by a medical provider and that the encounter is documented, before the patient is given a clinic appointment on a later date.

[10] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

## Comments

The VISN and facility Directors agreed with our findings and recommendations. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed

*(original signed by:)*
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

**Appendix A**

# VISN Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** January 5, 2011

**From:** Director, VA Southwest Health Care Network (10N18)

**Subject:** Healthcare Inspection- Imminent Danger to Patients, Southern Arizona VA Health Care System, Tucson, Arizona

**To:** Director, Management Review Service (10B5)

I concur with the facility response to the recommendations contained in the Healthcare Inspection report. Please see Medical Center Director's comments for specific actions. For questions, please contact Sally Compton, Executive Assistant to the Network Director, VISN 18, at 602.222.2699.

*(original signed by:)*

Susan P. Bowers

cc:
Office of Management and Administration, Operational Support Division (53B)
Associate Director, Seattle Regional Office of Healthcare Inspections (OIG)

**Appendix B**

# Medical Center Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** December 29, 2010

**From:** Director, Southern Arizona VA Health Care System (678)

**Subject:** Healthcare Inspection-Imminent Danger to Patients, Southern Arizona VA Health Care System, Tucson, Arizona

**To:** Director, VA Southwest Health Care Network (10N18)

1. The Southern Arizona VA Health Care System concurs with the findings and recommendations from the above healthcare inspection.
2. Please find attached our reponse to the recommendations provided in the report.
3. If you have any question regarding the response to the recommendations in the report, please contact me at (520) 629-1821.

*(original signed by:)*

Jonathan H. Gardner, FACHE

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

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

**OIG Recommendations**

**Recommendation 1.** We recommend that the Director ensures that the facility employs the ESI triage system according to VHA policy.

**Concur**

While the facility has employed the Emergency Severity Index (ESI) triage system in the Emergency Room, patients who had minor complaints, such as a common cold and an ESI score of 4 or 5 were then seen by an RN and given the option to wait to be seen in the ED or given an appointment in primary care clinic. This process has been terminated effective December 8, 2010. All patients are now seen by a provider in the ED.

Audits will be conducted monthly to assure compliance.

**Recommendation 2.** We recommend that the Director ensures that patients who present to the facility's Emergency Department are evaluated by a medical provider and that the encounter is documented, before the patient is given a clinic appointment on a later date.

**Concur**

Effective December 8, 2010, patients who present to the facility's Emergency Department (ED) are evaluated by a medical provider and the encounter is documented. All patients are now seen by a medical provider in the ED.

Audits will be conducted monthly to assure compliance.

**Appendix C**

# OIG Staff

| | |
|---|---|
| OIG Contact | Gail Bozzelli, RN<br>Seattle Office of Healthcare Inspections |
| | Jerome Herbers, MD |

**Appendix D**

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