Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Customer Care and Satisfaction
Southern Arizona VA Health Care System
Tucson, Arizona

Report No. 11-00233-137

March 31, 2011

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding customer care and satisfaction at the Casa Grande Community Based Outpatient Clinic (CBOC) in Casa Grande, AZ. The CBOC is part of the Southern Arizona VA Health Care System in Tucson, AZ.

The complainants specifically alleged that:

- A licensed practical nurse (LPN) took a patient's vital signs, did not document the patient's vital signs in the medical record, and then referred the patient to a local emergency room (ER).
- A provider did not appropriately examine two patients; CBOC front desk staff and management harass and treat patients rudely.
- There are increased complaints from patients regarding telephone wait times of up to 45 minutes to speak with pharmacy representatives.
- CBOC staff are harassing a patient by intercepting the patient's calls to CBOC providers or that the patient is out of pain medication and has been abandoned because of a lack of returned phone calls from the patient's primary care physician (PCP) and psychiatrist.

We substantiated that a patient presented to the CBOC for evaluation of bleeding and an LPN took the patient's vital signs but did not document them in the medical record. We did not substantiate that the LPN referred the patient to a local emergency room, that two patients received inappropriate examinations, that CBOC staff harassed or treated patients rudely, or that patient complaints regarding long telephone wait times to speak with pharmacy representatives had increased.

We did not substantiate that CBOC staff continue to harass a patient complainant or that providers have abandoned this patient. Mental health providers saw the patient twice since our onsite visit, and future appointments are scheduled with the CBOC psychiatrist. The patient also saw the CBOC PCP since our onsite visit and has future appointments scheduled. The patient's PCP has documented interventions regarding management of the patient's pain and there are multiple notes documenting telephone interactions between the patient and CBOC Mental Health and Social Work Service providers.

We made no recommendations.

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

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

SUBJECT: Healthcare Inspection – Customer Care and Satisfaction, Southern Arizona VA Health Care System, Tucson, Arizona

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) reviewed allegations regarding customer care and satisfaction at the Casa Grande Community Based Outpatient Clinic (CBOC) in Casa Grande, AZ. The purpose of the inspection was to determine if the allegations had merit.

Background

The CBOC is part of the Southern Arizona VA Health Care System (facility) in Tucson, AZ. The CBOC provides outpatient primary care services to approximately 3,000 unique veterans.

The facility provides acute care for veterans with inpatient and outpatient health care services. It is part of Veterans Integrated Service Network 18 and serves a patient population of about 173,000. The facility provides outpatient care at seven CBOCs located in Northwest Tucson, Southeast Tucson, Casa Grande, Green Valley, Safford, Sierra Vista, and Yuma, AZ.

In October 2010, two complainants contacted OIG's Hotline Division regarding customer care and satisfaction issues at the CBOC. The complainants specifically alleged that:

- A licensed practical nurse (LPN) took a patient's vital signs, did not document the patient's vital signs in the medical record, and then referred the patient to a local emergency room (ER).
- A provider did not appropriately examine two patients for their complaints.

- CBOC front desk staff and management harass and treat patients rudely.
- There are increased complaints from patients regarding telephone wait times of up to 45 minutes to speak with pharmacy representatives.

In January 2011, one of the complainants contacted OIG's Hotline Division regarding additional complaints about the harassment and abandonment of one of the patients in the original complaint. Specifically, the complainant alleged that:

- CBOC staff are harassing a patient by intercepting the patient's calls to CBOC providers, and the intended recipient of the call does not return the call.
- The patient is out of pain medication and has been abandoned because of a lack of returned phone calls from the patient's primary care physician (PCP) and psychiatrist.

Scope and Methodology

We interviewed the complainants by telephone prior to our site visit of the facility and CBOC on November 16–17, 2010. We also interviewed four of the five patients listed by one of the complainants as having relevant experiences at the CBOC. While onsite, we interviewed managers, clinicians, and other employees with key knowledge of the complaints. We reviewed facility and VHA policies, relevant medical records, and all CBOC patient complaints and customer feedback from October 1, 2009, through September 30, 2010.

One of the complainants made allegations that were beyond the scope of an OHI review. These allegations concerned labor relation and equal employment opportunity issues. This review focused on the allegations directly related to patient care and satisfaction.

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: Customer Care

We substantiated that a patient came to the CBOC for evaluation of bleeding, an LPN took the patient's vital signs, and the LPN did not document the patient's vital signs in the medical record. We did not substantiate that the LPN referred the patient to a local ER for treatment. We interviewed the patient and CBOC management and reviewed the patient's medical record. A registered nurse (RN) documented the interaction with the patient. The RN suggested that the patient go to a local ER or to the Tucson ER for evaluation. The patient's medical record did not contain vital signs obtained during the

encounter. By standard operating procedure (SOP) for patient triage,[1] an LPN may obtain patient vital signs; however, an RN is responsible for medical record documentation. The RN did not follow SOP and document the patient's vital signs in the medical record. CBOC management addressed the failure of the RN to follow SOP prior to our review.

We did not substantiate the allegation that a provider did not appropriately examine two patients for their complaints. We interviewed the two patients and reviewed their medical records. One of the patients reported that a provider failed to perform a foot exam during a clinic visit in December 2007 despite a diagnosis of diabetes; however, the patient's medical record documents a foot exam was performed during that visit. The second patient disagreed with the complainant and denied having inappropriate examinations at the CBOC.

Issue 2: Customer Service

We did not substantiate the allegation that CBOC staff harassed or treated patients rudely. We interviewed four of the five patients who reported CBOC customer service issues to one of the complainants, facility leadership, and CBOC management and staff. We reviewed all written CBOC patient complaints from October 1, 2009, through September 30, 2010, and all customer feedback provided through "Are You Satisfied?" forms[2] from program initiation in March 2010.

Although none of the interviewed patients described being harassed, two of the patients confirmed feeling rudely treated by CBOC staff as described by the complainant. However, the complainant did not accurately describe the issues encountered by the other two patients. One of the patients described an issue with another patient during group therapy, not with CBOC staff as described by the complainant. The second patient acknowledged that a CBOC provider made a one-time curt statement, but the patient felt that the provider was "simply having a bad day" and did not see a need to report it.

Two written complaints filed during our review period for the CBOC concerned staff courtesy. Facility and CBOC management addressed both complaints prior to our review. Of the 39 total "Are You Satisfied?" forms submitted during the review period, 38 (97 percent) were complimentary of CBOC staff and services.

We did not substantiate the allegation of increased complaints from patients regarding telephone wait times to speak with pharmacy representatives. For our review period, there were no complaints specific to pharmacy telephone wait times. Furthermore, although CBOC staff did not track verbal complaints, they felt the number of verbal complaints from patients regarding pharmacy telephone waits times had decreased. Facility leadership also described an ongoing system redesign project implemented in

[1] Triage is the process of determining the priority of patients' treatments based on the severity of their condition.
[2] Customer feedback forms are available for patients to fill out about their clinic visit.

early 2010 that reduced the pharmacy call volume and associated wait times to reach pharmacy representatives.

Issue 3: Additional Allegations of Patient Care

We did not substantiate the additional allegations that CBOC staff continue to harass the patient complainant or that providers have abandoned this patient.

Clinic staff handle all telephone calls that come into the CBOC for providers. Providers return calls as time allows during the workday. CBOC mental health (MH) providers and the PCP have documented that they have seen and spoken with the patient several times since our onsite visit.

During a return call from the CBOC MH social worker, the patient had an outburst of inappropriate language and made threats toward staff. The social worker followed protocol by filling out a behavior incident report and reporting the incident to the police. However, this did not affect his treatment. There is documentation of scheduled follow-up appointments for pain, mental health, and primary care; and there are current active prescriptions for medications that will provide enough medications until the patient's next appointment.

The PCP has documented discussions with the patient about pain management. The patient has been seen by physical therapy, had pain medication adjusted, and a consult was sent for the patient to be seen in the chronic pain management clinic. The PCP has made appropriate referrals.

Conclusions

We did not find evidence of widespread problems related to customer care or satisfaction at the CBOC. CBOC and facility management promote a patient-centered atmosphere and take appropriate actions when employees do not meet this expectation.

There is no evidence to suggest that harassment or abandonment by providers occurred toward the identified patient. The patient was seen several times since our visit, there is documentation of returned calls to the patient, and the patient has future appointments for care at the facility.

We made no recommendations.

Comments

The VISN and facility Directors concurred with our findings (see Appendixes A and B, pages 6–7, for the Directors' comments). We made no recommendations and plan no further actions.

(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: March 23, 2011

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

Subject: **Healthcare Inspection – Customer Care and Satisfaction, Southern Arizona VA Health Care System, Tucson, Arizona**

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

Thru: Director, Management Review Service (10B5)

1. I concur with the facility response to the Healthcare Inspection report. Please see Facility Director Comments for specific actions.

2. For questions, please contact Sally Compton, Executive Assistant to the Network Director, VISN 18, at (602) 222-2699.

(*original signed by*:)
Susan P. Bowers
Director, VA Southwest Health Care Network (10N18)

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 23, 2011

From: Director, Southern Arizona VA Health Care System (678/00)

Subject: **Healthcare Inspection – Customer Care and Satisfaction, Southern Arizona VA Health Care System, Tucson, Arizona**

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

1. The Southern Arizona VA Health Care System has reviewed and concurs with the report regarding your review of issues at our Casa Grande Community Based Outpatient Clinic (CBOC) in Casa Grande, AZ.

2. The omission by the CBOC RN to follow the standard operating procedure for patient triage has been addressed with the RN as annotated in your report. Professional practice reviews are occurring to insure appropriate practices.

3. If you have any questions regarding these comments, please contact me at (520) 629-1821.

(original signed by:)

Jonathan H. Gardner, MPA, FACHE
Director, Southern Arizona VA Health Care System (678/00)

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Cathleen King, RN, Associate Director Dallas Office of Healthcare Inspections
Acknowledgments	Larry Ross, MS, Team Leader Gayle Karamanos, PA George Wesley, MD Misti Kincaid, BS, Program Support Assistant

Appendix D

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