



Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-02241-375

Healthcare Inspection
**Delayed Access to Primary Care,
Contaminated Reusable
Medical Equipment, and Follow-Up of
Registered Nurse Staffing Concerns
Southern Arizona
VA Health Care System
Tucson, Arizona**

September 26, 2017

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the request of Senator John McCain, Senator Jeff Flake, Congresswoman Martha McSally, former Congresswoman Ann Kirkpatrick, and Congressman Raúl M. Grijalva to assess the merits of allegations related to patients' delayed access to primary care and contaminated reusable medical equipment (RME) at the Southern Arizona VA Health Care System (system), Tucson, AZ. The allegations received in 2016 were:

- The number of primary care patient appointments taking 30 days or more to schedule had increased from fiscal year (FY) 2015 to FY 2016.
- RME may have been contaminated and inappropriately reused on patients as a result of reduced staffing.

We also followed up on concerns identified in the FY 2014 Employee Assessment Review survey¹ about registered nurse staffing in specific units.

We substantiated that the number of primary care patient appointments taking 30 days or more to schedule had increased from FY 2015 to FY 2016. We compared Veterans Health Administration's Veterans Support Services Center data for new and established patient appointments for FYs 2015 and 2016, quarters 1 and 2. We found an increase in the number of both new and established patients waiting more than 30 days from the preferred date to the appointment date.^{2,3}

We determined that primary care wait times were affected by complex scheduling templates containing different appointment types and provider vacancies in rural community based outpatient clinics. System leaders identified provider vacancies as affecting primary care wait times and took action to increase physician recruitment efforts by offering financial incentives to attract providers to a rural clinic. They used gap⁴ providers to supplement staffing during the winter months to assist with an influx of patients. As of August 1, 2016, all provider positions at the rural clinic were filled.

While we substantiated that RME (endoscopes) were contaminated and inappropriately reused in two incidents, we did not substantiate that it was due to reduced staffing. We found this was a Sterile Processing Services (SPS) process issue.

¹ The Employee Assessment Review survey is an anonymous survey distributed to system employees by the OIG in conjunction with Combined Assessment Program reviews. The Employee Assessment Review survey offers all system staff the opportunity to express their opinions about patient safety at the system.

² The preferred date or patient's desired date is the date that a patient prefers to be seen. In this report, only the wait time from the preferred date is used for wait time measures.

³ The data may not reflect the actual wait time because, in part, the wait time data are an average of all appointments, including urgent and walk-in patient appointments. Urgent and walk-in patient appointments have relatively short wait times compared to routine follow-up appointments. Therefore, the percentage of patients seen greater than 30 days from the preferred date may be greater.

⁴ Gap positions were created by the system to cover providers on leave or vacant primary care provider positions throughout primary care.

During the two incidents, which occurred in August and December 2014, improperly disinfected endoscopes were reused on patients. Each incident was the result of an SPS staff member's failure to follow the process for verifying that the endoscopes were disinfected. Staff notified the patients involved, who agreed to laboratory testing, which was completed. The patients did not experience adverse outcomes related to the improperly disinfected endoscopes.

After the incidents, but prior to our inspection, SPS managers modified the RME process and provided additional training for SPS staff members to address the incidents of improper disinfection and reuse of RME. Therefore, we made no recommendations for this allegation.

We verified that system leaders took action and demonstrated continued improvement of registered nurse staffing in the inpatient medical/surgical and mental health units, the community living center, the special procedures unit, and the Emergency Department.

We recommended that the System Director ensure that primary care appointment scheduling processes are assessed and action is taken to ensure timely access for new and established patients.

Comments

The Veterans Integrated Service Network and System Directors concurred with our recommendation and provided an acceptable action plan. (See Appendixes A and B, pages 11–13 for the Directors' comments.) We will follow up on the planned actions until completed.



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

Purpose

At the request of Senator John McCain, Senator Jeff Flake, Congresswoman Martha McSally, former Congresswoman Ann Kirkpatrick, and Congressman Raúl M. Grijalva, the VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the merits of allegations related to patients' delayed access to primary care and contaminated reusable medical equipment (RME) at the Southern Arizona VA Health Care System (system), Tucson, AZ. We also followed up on registered nurse (RN) staffing concerns identified in the fiscal year (FY) 2014 Employee Assessment Review (EAR) survey.⁵

Background

The system is a tertiary care referral hospital located in Tucson, AZ, serving approximately 171,000 patients and is part of Veterans Integrated Service Network (VISN) 22. Primary care and subspecialty referral services are provided to patients from the Phoenix, Tucson, Prescott, and El Paso primary service areas. The system has 283 authorized beds and includes 7 community based outpatient clinics (CBOC) located in Safford, Casa Grande, Sierra Vista, Yuma, Green Valley, Northwest, and Southeast Tucson, AZ.

Prior Reports

OIG conducted a routinely scheduled healthcare inspection of the system. Results of this review were published in *Combined Assessment Program Review of the Southern Arizona VA Health Care System, Tucson, Arizona*, (Report No. 14-00305-123, April 14, 2014). OIG made 19 recommendations and all were closed by February 20, 2015.

OIG conducted a criminal investigation regarding scheduling practices at the system. Results of this review were published in *VA OIG Administrative Summary VA Medical Center⁶ in Tucson, Arizona*, (14-02890-353, November 8, 2016). OIG referred the Report of Investigation to VA's Office of Accountability Review on August 10, 2016.

OIG conducted an audit inspection of the system's scheduling processes. Results of this review were published in *Review of Alleged Wait-Time Manipulation at the Southern Arizona VA Health Care System*, (Report No. 14-02890-72, November 9, 2016). OIG recommended that system leaders ensure that schedulers comply with current Veterans Health Administration (VHA) policy regarding scheduling policies and practices. The Director of VISN 22 concurred with the findings and recommendations and submitted

⁵ The EAR survey is an anonymous survey distributed to system employees by the OIG in conjunction with Combined Assessment Program reviews. The EAR survey offers all system staff the opportunity to express their opinions about patient safety at the system.

⁶ The report was published indicating that the facility was designated as a Medical Center versus a Health Care System.

acceptable corrective action plans. As of July 10, 2017, all recommendations remained open.

Allegations

In February, March, and April 2016, we received requests from Senator John McCain, Senator Jeff Flake, Congresswoman Martha McSally, former Congresswoman Ann Kirkpatrick, and Congressman Raúl M. Grijalva regarding allegations related to delayed access to primary care and contaminated RME at the system. Specifically, the allegations were:

- The number of primary care patient appointments taking 30 days or more to schedule had increased from FY 2015 to FY 2016.
- RME may have been contaminated and inappropriately reused on patients as a result of reduced staffing.

We also followed up on RN staffing concerns identified in the FY 2014 OIG Combined Assessment Program Review EAR survey. The RN staffing concerns were in the inpatient medical/surgical and mental health units, the community living center (CLC), the special procedures unit (SPU), and the Emergency Department (ED).

Scope and Methodology

We conducted this inspection from April through November 2016. We made a site visit to the system April 25–29, 2016.

We interviewed the VA Central Office National Director for Primary Care Operations by telephone. We interviewed the following VHA personnel onsite: Acting System Director; Acting Chief of Staff; Associate Director for Patient Care Services; Chief of Primary Care Services; Primary Care Support Supervisor, primary care providers (PCP), managers, nurses, and medical support assistants (MSA); Chief of Clinic Operations for Group Practice Management; Chief of Sterile Processing Services (SPS); SPS supervisors and staff members; Patient Safety Manager; Infection Prevention Nurse; Nurse Recruiter; Patient Advocate; inpatient medical/surgical and mental health nurse managers and nurses; and a Human Resources Management Services representative.

We reviewed VHA and system policies and procedures, meeting minutes, VHA Corporate Data Warehouse data,⁷ VHA Support Services Center (VSSC) reports, electronic health records, staff training records, and other relevant documents.

⁷ The Business Intelligence Service Line is the section of the Office of Information and Technology that maintains a set of servers and other information technology resources that provide clinical and other data to VA for analytical purposes. Each server contains a national data set, a regional data set or a VISN data set. The term “Corporate Data Warehouse” is often used to mean the system overall as the metadata and other documentation apply to all environments.

VHA primary care wait time data are maintained in the VSSC.⁸ Timeliness of appointments is calculated by the preferred date, the date a patient prefers to be seen, or the date the provider deems clinically indicated. VHA previously referred to the preferred date and/or the clinically indicated date as the desired date.⁹ VHA specified a wait time policy of not more than 30 days from the preferred date.¹⁰

To address the FY 2014 EAR survey RN staffing concerns, we reviewed the system's nurse staffing methodology from FY 2014 through FY 2016, human resources documents and data, and actions taken by system leaders.

VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010 cited in this report expired July 31, 2015 and has not been updated. We considered this policy to be in effect as it had not been superseded by more recent policy or guidance. In a June 29, 2016 memorandum to supplement policy provided by VHA Directive 6330(1),¹¹ the VA Under Secretary for Health (USH) mandated the "...continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."¹² The USH also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "...the timely rescission or recertification of policy documents over which their program offices have primary responsibility."¹³

We substantiate allegations when the facts and findings supported 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.

⁸ VSSC provides data within its stewardship to establish internal VA organization/program offices for the purpose of health care delivery analysis and evaluation.

⁹ VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016.

¹⁰ U.S. Government Accountability Office, Report to Congressional Requesters, *VA Mental Health Clearer Guidance on Access Policies and Wait-Time Data Needed*, October 2015.

¹¹ VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.

¹² VA Under Secretary for Health Memorandum, *Validity of VHA Policy Document*, June 29, 2016.

¹³ Ibid.

Inspection Results

Issue 1: Access to Primary Care

We substantiated that the number of primary care patient appointments taking 30 days or more to schedule had increased from FY 2015 to FY 2016. We compared VSSC patient wait time data for FY 2015 quarters 1 and 2 with FY 2016 quarters 1 and 2 and found an increase in the number of new and established patients who waited more than 30 days for a primary care appointment.¹⁴

A. Primary Care Wait Times

VSSC Wait Time Data. We reviewed VSSC wait time data for new¹⁵ and established¹⁶ patient appointments from October 1, 2014 through March 31, 2016.¹⁷ We compared patient wait time data for FY 2015 quarters 1 and 2 with FY 2016 quarters 1 and 2. We found an increase in the number of new and established patients waiting more than 30 days from the patients' preferred date to the appointment date:

- Quarter 1 of FYs 2015 and 2016:
 - New patients: 17 of 1,853 (0.9 percent) and 58 of 914 (6.4 percent), respectively.
 - Established patients: 683 of 17,989 (3.8 percent) and 1,045 of 18,010 (5.8 percent), respectively.
- Quarter 2 of FYs 2015 and 2016:
 - New patients: 62 of 1,994 (3.1 percent) and 78 of 926 (8.4 percent), respectively.
 - Established patients: 1,013 of 19,947 (5.1 percent) and 1,175 of 18,920 (6.2 percent), respectively.

B. Possible Factors Associated with Wait Times More than 30 Days

Primary Care Appointment Scheduling. Primary care MSAs told us that not enough primary care appointment slots were available to schedule routine patient appointments within 30 days of the patient's preferred date. Staff told us that if patients were in need of follow-up appointments and could not be scheduled within 30 days of the preferred

¹⁴ The data may not reflect the actual wait time because, in part, the wait time data are an average of all appointments, including urgent and walk-in patient appointments. Urgent and walk-in patient appointments have relatively short wait times compared to routine follow-up appointments. Therefore, the percentage of patients seen greater than 30 days from the preferred date may be greater.

¹⁵ A new patient is a patient who has not had a completed visit in a VHA clinic for the past 24 months.

¹⁶ An established patient is a patient who has had at least one prior completed visit in the past 24 months in a VHA clinic.

¹⁷ A prior OIG report identified a use of improper scheduling processes. We did not review that issue in this report. VAOIG Report No. 14-02890-72, *Review of Alleged Wait-Time Manipulation at the Southern Arizona VA Health Care System*, November 9, 2016.

date, they offered the Choice Program.¹⁸ Most patients declined a Choice referral and chose to wait for appointments with their Patient Aligned Care Team (PACT)¹⁹ PCP. For example, from February 19, 2016 through May 18, 2016, staff offered the Choice Program to 442 patients. Of the 442 patients, 351 (79 percent) chose to wait for an appointment with their PCP at the system.

In addition, PCP clinic schedules contained multiple appointment types including routine appointments, urgent visits, hospital discharges, and telephone clinics.²⁰ The clinic schedule included 2 hours of non-bookable “flex time” for PCPs to address walk-in patients and to perform administrative tasks. Table 1 is an example of the system’s PACT Clinic daily schedule for a full time PCP.

Table 1. Example of a PACT PCP Clinic Schedule.

Time	Monday	Tuesday	Wednesday	Thursday	Friday
8:00am	Telephone clinic	Telephone clinic	PCL Meetings	Telephone clinic	Telephone clinic
8:30am	MSA scheduled visit	MSA scheduled visit	PCL Meetings	MSA scheduled visit	MSA scheduled visit
9:00am	MSA scheduled visit	MSA scheduled visit	PCL Meetings	MSA scheduled visit	MSA scheduled visit
9:30am	MSA scheduled visit	MSA scheduled visit	PCL Meetings	MSA scheduled visit	MSA scheduled visit
10:00am	Hospital Discharge				
10:30am	Nurse scheduled visit				
11:00am	Nurse scheduled visit				
11:30am	Flex time				
12:00pm	Lunch	Lunch	Lunch	Lunch	Lunch
12:30pm	Flex time				
1:00pm	Nurse Schedule visit				
1:30pm	MSA scheduled visit				
2:00pm	MSA scheduled visit				
2:30pm	MSA scheduled visit				
3:00pm	Flex time				
3:30pm	Flex time				
4:00pm	Telephone clinic				

Source: System internal documents

PCL Meeting= Primary Care Line Meeting

MSA scheduled visit = routine appointments only scheduled by MSAs

Nurse scheduled visit = urgent appointments and walk-in patients only scheduled by nurses

Flex time = walk-in patients and administrative tasks

¹⁸ The Choice Program allows the patient, who is already enrolled in VA health care, to receive health care within the community. Using this program does not impact existing VA health care or any other benefit.

¹⁹ PACT is a team-based model of care led by a personal provider who enables continuous and coordinated care throughout a patient's lifetime to maximize health outcomes.

²⁰ Telephone clinics are designed to provide a non-traditional manner in which patient care can be delivered.

Telephone encounters between physicians and patients include evaluation and management of medical conditions.

Complex schedules with multiple appointment types can increase inefficiencies and wait times because unutilized appointments in one category (appointment type) may not be accessible to patients in other appointment categories.

For example, MSAs schedule patients requiring routine follow-up appointments for chronic, stable medical conditions. Demand for this type of appointment is driven by the PCP's panel size and the return visit rate per patient for routine appointments. For instance, a full time provider who has 1,200 patients, works 250 days a year (assumes no leave), and has 6 routine slots for scheduling per day (see Table 1), would only be able to see each patient for routine follow-up appointments 1.25 times per year. These patients may not be scheduled into other unutilized types of appointments or unbookable "flex" time; thus, return visit rates of >1.25 times per year would lead to longer wait times for patients requiring more frequent follow up. The affected patients are often those who have more chronic illnesses requiring complex medical care.

Provider Vacancies. Staff told us that recruitment of PCPs at the CBOCs was challenging, mostly due to the remoteness of the rural clinics. In particular, staff identified the Yuma CBOC as lacking a permanent PCP from April through December 2015. System leaders implemented a \$20,000 PCP recruitment incentive for the Yuma CBOC, and as of August 1, 2016, all provider positions were filled.

In FY 2014, system leadership created two "gap" provider positions intended to cover providers on leave or vacant PCP positions throughout primary care. As of August 2, 2016, system leaders increased the number of gap positions and had three full-time gap providers on staff.

PCP full-time equivalent (FTE) employees increased²¹ and vacancies decreased from FY 2014 to FY 2016 through May 6, 2016 (see Table 2).

Table 2. PCP Vacancies for FY 2014, FY 2015, and FY 2016 through May 6, 2016.

FY	Approved PCP FTEs	PCP Vacancies
2014	37	8
2015	44	7
2016	44	6

Source: System Human Resources Department

Increase of Patients During Winter Months. System staff told us that an influx of patients during the winter months negatively affected access to primary care. We were told that from October 1, 2015 through April 30, 2016, there were 1,469 unique patients with home addresses outside of the system's catchment area; those patients accounted for 4,865 primary care encounters. However, we were unable to verify this information

²¹ FTE employees are full-time employees who worked on average 30 hours or more a week for more than 120 days in a year or the number of employees that are expected to work these hours.

with VSSC data. In response to the reported increase in patients, staff overbooked appointment slots and providers increased the use of non-traditional access encounters, such as telephone clinics and secure messaging.²² System leaders used locum tenens physicians,²³ fee basis non-VA providers,²⁴ and gap providers to assist with the surge of patients.

Issue 2: Improper Disinfection of RME

While we substantiated that RME (endoscopes) were contaminated and inappropriately reused in two incidents, we did not substantiate that it was due to reduced staffing. We reviewed the electronic health records for the patients at risk and did not find adverse outcomes related to improperly disinfected endoscopes. We found that system staff completed a clinical disclosure and testing for each patient involved and determined that no further follow up was needed. System staff also completed a Root Cause Analysis of the incidents to determine the reason for the improper disinfection of RME and what corrective actions should be taken to reduce the possibility of future incidents.²⁵

Incidents of Improper Disinfection of RME. VHA Directive 2009-031 states that “Proper reprocessing²⁶ of RME is a key component to ensuring patient and staff safety, and therefore must be performed to exacting standards.”²⁷ In August and December 2014 the system had two incidents of improper disinfection of endoscopes²⁸ which were used on patients. SPS leaders were informed of the December 2014 incident, staff reviewed endoscope disinfection logs, and subsequently identified the August incident.

We did not find that reduced staffing contributed to the incidents; however, system leaders acknowledged that SPS staff vacancies existed in FY 2014 and FY 2015. SPS leaders told us that the incidents were the result of employees’ failures to follow the correct processes. The employees involved in the incidents were reassigned to a different department at the system.

²² Secure messaging is a secure web-based messaging service that allows patients and their health care teams to communicate non-urgent, non-emergent health related information.

²³ Locum tenens physicians are providers who fill a position for a specified time or temporarily take the place of another physician. They are commonly hired by a contracting company to provide the service.

²⁴ Fee basis providers are non-VA employees who work in the VA on a fee basis. Unlike locum tenens providers, they are not hired through a contracting company.

²⁵ A Root Cause Analysis is an investigation into an incident to find out what happened, why it happened, and to determine what can be done to prevent it from happening again.

²⁶ Reprocessing includes the uniform implementation of current manufacturers’ instructions for cleaning, disinfection, and sterilization of RME.

²⁷ VHA Directive 2009-031, *Improving Safety in the Use of Reusable Medical Equipment through Standardization of Organizational Structure and Reprocessing Requirements*, June 26, 2009. This directive was in effect during the time of the events discussed in this report. The directive was rescinded and replaced by VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016. Both directives have the same or similar requirements regarding RME reprocessing.

²⁸ An endoscope is an illuminated, usually fiber-optic, flexible or rigid tubular instrument for visualizing the interior of a hollow organ or part for diagnostic or therapeutic purposes such as a colonoscopy.

In the December 2014 incident, the Medivator²⁹ produced a Disinfection Cycle Log (DCL) print-out³⁰ with two results, a “cycle pass” and “cycle fail” for the same endoscope. However, the Medivator should have produced one result. A fail result indicates that the Medivator did not disinfect the endoscope properly. This incident was the result of staff’s failure to follow reprocessing protocol as well as a malfunctioning Medivator. SPS leaders told us that a staff member allowed the endoscope to go out of the reprocessing area with a cycle fail disinfection result. SPS leaders also told us that an investigation of the incident by managers found that the Medivator was not functioning properly; the machine was subsequently repaired.

As a result of the December incident, SPS leaders conducted a retrospective review of the Medivator DCL print-outs from August through November 2014 and found another incident in which an endoscope had a cycle fail result on August 19. This endoscope was used on a patient on August 20.

SPS Leaders’ Response to Incidents of Improper Disinfection of RME. SPS leaders were made aware of the December 15, 2014 incident 15 days after it occurred. Upon learning of the incident, staff reviewed endoscope disinfection logs, and identified the August incident. SPS leaders identified the patients involved in both incidents. The patients agreed to follow-up laboratory testing and did not have adverse outcomes related to use of these two endoscopes.

In addition, SPS leaders changed their RME cleaning process to include staff performing a double check of the DCL print-out from the Medivator after endoscope reprocessing. The process required a staff member to verify and circle a pass result on the DCL print-out before it was affixed to the endoscope. The end user must confirm that a cycle pass result was attached to the endoscope prior to use on a patient.

SPS staff also attended weekly meetings and received training on reprocessing of RME including endoscopes, which we confirmed through interviews. We reviewed SPS staff members’ competencies and found that competency documentation was completed as required.

Issue 3: EAR Survey RN Staffing Concerns

We verified that system leaders took action to follow up on the FY 2014 EAR Survey RN staffing concerns. From FY 2014 through FY 2016, we found continued improvement of RN staffing in the inpatient medical/surgical and mental health units, the CLC, the SPU, and the ED.

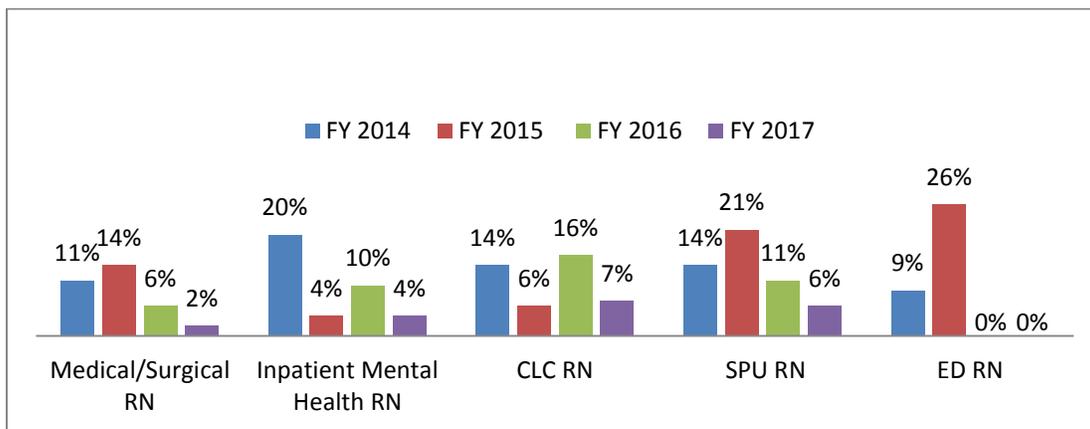
RN Vacancies. We reviewed RN staffing from October 1, 2013 through February 23, 2017 and found that the system had a decrease in RN vacancies. As of

²⁹ The Medivator is a machine used for reprocessing equipment and is intended for the washing and high level disinfection of endoscopes after Gastroenterology procedures.

³⁰ DCL is a report that prints out from the Medivator at completion of the reprocessing cycle with the run cycle data recorded.

February 23, 2017, we found 1 of 53 RN positions on the inpatient medical/surgical unit, 1 of 26 RN positions on the inpatient mental health unit, 2 of 36 RN positions in the SPU, and 3 of 44 RN positions in the CLC to be vacant. We found no vacancies in the ED. Despite fluctuations, the most recent RN vacancy rates for the inpatient medical/surgical and mental health units, the CLC, the SPU and the ED had decreased and for four of the five units, were at their lowest levels since FY 2014. (See Figure 1.)

Figure 1. Approved FTEs/RN Vacancies FY 2014–FY2016 through February 23, 2017.



Source: System internal documents

Vacancies - Percent of total number of approved FTEs that are vacant

RN Turnover Rates. We reviewed VSSC data related to RN turnover rates for FYs 2014, 2015, and 2016 and found that the RN turnover rate had decreased yearly since FY 2014. System RN turnover rates fell from 13.5 percent in FY 2014 to 7.88 percent in FY 2016.

We also reviewed the system’s nurse staffing methodology documentation from FY 2014 through FY 2016³¹ and found that the methodology was implemented as required by VHA policy.³²

Conclusions

We substantiated that the number of primary care patient appointments taking 30 days or more to schedule had increased from FY 2015 to May 6, 2016. We compared VSSC data for new and established patient appointments for FYs 2015 and 2016, quarters 1 and 2. We found an increase in the number of both new and established patients waiting more than 30 days from the preferred date to the appointment date.

³¹ The Staffing Methodology for VHA Nursing Personnel provides a nationally standardized method to determine appropriate direct care nurse staffing.

³² VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010. This directive expired July 31, 2015 and has not been updated.

We determined that primary care wait times were affected by complex scheduling templates containing different appointment types and provider vacancies in the system's rural community based outpatient clinics. To improve patients' primary care wait times, system leaders increased physician recruitment by offering financial incentives and hired providers to supplement staffing during physician vacancies and to assist with the influx of "snowbird" patients during the winter months.

While we substantiated that RME (endoscopes) were contaminated and inappropriately reused in two incidents, we did not substantiate that it was due to reduced staffing. In the two incidents, which occurred in August and December 2014, improperly disinfected endoscopes were used on patients. Each incident was the result of an SPS staff member's failure to follow the process for verifying that endoscopes were disinfected. Staff notified the patients involved, laboratory testing was negative, and we found that these patients did not experience adverse outcomes related to the improperly disinfected endoscopes. In response to the 2014 incidents, SPS leaders improved their process for disinfecting RME. In addition, SPS leaders initiated weekly meetings and provided training for SPS staff members on reprocessing of RME, including endoscopes. We made no recommendations for this allegation.

We also followed up on concerns identified in the FY 2014 EAR survey about RN staffing in specific units. We verified that system leaders took adequate action and demonstrated continued improvement of RN staffing in the inpatient medical/surgical and mental health units, the CLC, the SPU, and the ED.

Recommendation

We recommended that the System Director ensure that primary care appointment scheduling processes are assessed and action is taken to ensure timely access for new and established patients.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: August 3, 2017

From: Director, Desert Pacific Healthcare Network (10N22)

Subj: Healthcare Inspection—Delayed Access to Primary Care, Contaminated Reusable Medical Equipment, and Follow-Up of Registered Nurse Staffing Concerns, Southern Arizona VA Health Care System, Tucson, Arizona

To: Director, San Diego Office of Healthcare Inspections (54SD)
Director, Management Review Service (VHA 10E1D MRS Action)

1. I have reviewed and concur with the OIG Draft Report, Delayed Access to Primary Care, Contaminated Reusable Medical Equipment, and Follow-Up of Registered Nurse Staffing Concerns, Southern Arizona VA Health Care System, Tucson, Arizona.
2. If you have any questions, or require further information, please contact Terri Elsholz, Deputy Quality Management Officer, at (480) 397-2782.



MARIE L. WELDON, FACHE
Network Director, VISN 22 (10N22)

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: July 31, 2017
From: Director, Southern Arizona VA Health Care System, (678/00)
Subj: Healthcare Inspection—Delayed Access to Primary Care, Contaminated Reusable Medical Equipment, and Follow-Up of Registered Nurse Staffing Concerns, Southern Arizona VA Health Care System, Tucson, Arizona
To: Director, Desert Pacific Healthcare Network (10N22)

1. In response to your memo titled “Delayed Access to Primary Care, Contaminated Reusable Medical Equipment, and Follow-Up of Registered Nurse Staffing Concerns; Southern Arizona VA Health Care System,” please find the attached facility response to Recommendation 1.
2. If you have any questions or require additional information, please contact Dr. Anthony Stazzone, Chief of Staff at (520) 792-1450, extension 1815.

(original signed by:)

William J. Caron, FACHE
Director, Southern Arizona VA Health Care System

Comments to OIG's Report

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

OIG Recommendation

Recommendation. We recommended that the System Director ensure that primary care appointment scheduling processes are assessed and action is taken to ensure timely access for new and established patients.

Concur

Target date for completion: March 30, 2018

Facility response: In December 2016, Primary Care implemented an action plan to increase bookable clinic time for our Primary Care Providers by 23 percent. This increased clinic capacity by a total of approximately 72 slots per week.

Access for established Veterans across our system improved significantly. Established Veterans waiting over 30 days improved from 5.8 percent in Quarter 1 FY 2016 to 1.6 percent in Quarter 2 FY 2017. Over the last 6 months (February 2017 through July 2017) we have sustained an average wait for established Veterans of 3.7 days from patient indicated date (PID).

Access for new Veterans waiting over 30 days improved from 6.4 percent in Quarter 1 FY 2016 to 1.5 percent in Quarter 1 FY 2017, and from 8.4 percent in Quarter 2 FY 2016 to 3.0 percent in Quarter 2 FY 2017. While we have had improvement in new Veterans waiting over 30 days from preferred date; we still have challenges with the number of new Veterans waiting over 30 days from create date based on completed appointment data through July 2017.

In April 2017, the VA changed the metric used to measure new Veteran access. The VA now measures access from create date to appointment date. Over the last 6 months (February 2017 through July 2017) our average wait for new Veterans was 29.6 days. Our greatest challenges currently are with new Veteran access at the Casa Grande CBOC, Green Valley CBOC, Northwest CBOC, and the Tucson main campus.

The facility is currently taking the following actions to improve new Veteran access to primary care:

- Increase bookable time to 80/20 (clinical/administrative) for our primary care providers by September 30, 2017
- Standardization of clinical grids for primary care by September 30, 2017

We believe our current initiatives to standardize clinic profiles will result in improved access for our Veterans requiring new patient appointments. We anticipate being able to meet all new patient Primary Care access within 30 days by March 2018.

OIG Contact and Staff Acknowledgments

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