



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 14-05128-51

Healthcare Inspection

An Analysis of Mental Health, Primary Care, and Specialty Care Productivity and Related Issues El Paso VA Health Care System El Paso, Texas

December 2, 2014

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted a review in response to concerns raised by Congressman Beto O'Rourke regarding access to care at the El Paso VA Health Care System (EPVAHCS). The purpose of this review was to determine the extent to which those concerns had merit.

To examine veterans' access to care and factors that affected access, we reviewed relevant Veterans Health Administration (VHA) and facility data, including data on productivity, staffing, appointment availability, and workload. We reviewed these data for primary care and mental health clinics as well as two medical specialty clinics (cardiology and gastroenterology) and two surgical specialty clinics (orthopedics and urology) that we judgmentally selected. Our review of the data informed questions for interviews with EPVAHCS leadership and clinical and administrative staff during on-site visits.

We substantiated the concerns expressed. We found the many veterans seeking care at the EPVAHCS faced challenges accessing care timely, particularly patients that were new to EPVAHCS. The timeliness of veterans' access to care exceeded the 30-day benchmark established by the VA Secretary for three of four specialties included in our review—orthopedics, urology, and cardiology. In contrast, three EPVAHCS clinics met the 30-day access benchmark—primary care, mental health care, and gastroenterology.

We also found that numerous factors affected the timeliness of veterans' access to care at the EPVAHCS, including staffing, productivity, and clinic cancellations and no shows. We explored these factors, as well as other key issues and management challenges described by officials we interviewed, and their impact on access.

Efforts to improve access at the EPVAHCS should consider the factors we described in this report, both individually and in combination.

We made 11 recommendations. We recommended that the Facility Director:

- Review clinic productivity and implement a plan to enhance productivity in those clinics for which productivity is an issue.
- Ensure clinical departments accurately capture provider workload.
- Direct clinical departments to review labor mapping to ensure the labor mapping is up to date and accurately reflects the percentage of provider time allocated to direct patient care.
- Review the quadrants into which mental health, primary care, and specialty care clinics appear on the VHA Specialty Productivity-Access Report and Quadrant (SPARQ) tool, and evaluate and address underlying factors.

- Take measures to promote alignment of organizational structure with clinic centered accountability, goals, and expectations.
- Revise policy and/or processes to facilitate primary care Patient Aligned Care Team (PACT) operation, and support PACT model workflow and intra-clinic coordination of care.
- Identify specialties particularly vulnerable to loss of a provider and explore contingency plans to potentially mitigate the impact of provider loss on clinic disruption.
- Take measures to promote non-provider to provider communication within mental health, primary care, and specialty clinics.
- Consider inter-service agreements between primary care and specialty care clinics.
- Direct mental health clinic leadership to evaluate access and patient engagement for specific types of outpatient mental health services, including individual psychotherapy and intensive substance use treatment, in order to provide a more encompassing picture of mental health access.
- Provide a quarterly update on facility efforts to revise outpatient mental health clinic processes to promote greater continuity of care through the regular outpatient mental health clinic and to better focus the walk-in clinic toward serving those in need of walk-in care.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations (except for recommendation 9, which they indicated had already been accomplished) and provided an acceptable action plan. (See Appendixes D and E, pages 22–28 for the Directors’ comments.) We will follow up on the planned actions until they are completed.



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Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review in response to concerns raised by Congressman Beto O'Rourke regarding access to care at the El Paso VA Health Care System (EPVAHCS). The purpose of this review was to determine the extent to which those concerns had merit.

Background

The EPVAHCS comprises a VA medical center (VAMC) in El Paso, TX and Community Based Outpatient Clinics in East El Paso, TX, and Las Cruces, NM. In fiscal year (FY) 2014, more than 41,000 veterans were enrolled in the EPVAHCS, about 30,000 of whom received services through the system. The VAMC, which is located adjacent to an Army Medical Center, and Community Based Outpatient Clinics provide primary care and specialized ambulatory care services.¹ The VAMC does not directly provide inpatient or emergency room services and instead purchases those services from the Army, local private hospitals, the New Mexico VA Health Care System in Albuquerque, or other VAMCs in the region. EPVAHCS is part of Veterans Integrated Service Network (VISN) 18.

According to the Institute of Medicine, access to health care means having “the timely use of personal health services to achieve the best health outcomes.”² The VA OIG has published numerous reports that raise concerns about the timeliness of veterans’ access to VA health care services across the Veterans Health Administration (VHA).³ This report is in response to concerns raised by Representative O'Rourke about access to care at the EPVAHCS. In particular, this report accomplishes the following:

1. Describes veterans’ access to mental health (MH), primary care, and selected specialty care at the EPVAHCS.
2. Examines factors that affected veterans’ access to MH, primary care, and selected specialty care at the EPVAHCS, including staffing and productivity and efficiency in terms of workload and clinic operations.

¹The El Paso VAMC is located on Fort Bliss, the second largest U.S. Army installation, which is currently home to 30,000 soldiers and their families.

²Institute of Medicine, Committee on Monitoring Access to Personal Health Care Services. Access to health care in America. Washington, DC: National Academy Press; 1993.

³See, for example, *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*, (Report No. 14-02603-267, August 26, 2014).

Scope and Methodology

To examine veterans' access to care and factors that affected access, we reviewed relevant VHA and facility data, including data on productivity, staffing, appointment availability, and workload. We reviewed these data for primary care and MH clinics as well as two medical clinics (cardiology and gastroenterology) and two surgical specialty clinics (orthopedics and urology) that we judgmentally selected. Our review of the data informed questions for interviews with EPVAHCS leadership and clinical and administrative staff during on-site visits over the weeks of April 28, August 25, and September 15, 2014. In addition, we interviewed leadership from pertinent VHA program offices, namely the Office of Operational Analytics and Reporting and the Office of Productivity, Efficiency, and Staffing (OPES).

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: Access to Mental Health, Primary Care, and Selected Specialty Care

We substantiated the concerns expressed. Many veterans seeking care at the EPVAHCS faced challenges accessing care timely, particularly patients that were new to that System. The timeliness of veterans’ access to care exceeded the 30-day benchmark established by the VA Secretary for three of four specialties included in our review—orthopedics, urology, and cardiology.⁴ In contrast, three EPVAHCS clinics met the 30-day access benchmark—primary care, MH care, and gastroenterology. (See Table 1 for more detailed information on access.)

Table 1. Average Number of Days Until the Third Next Available Appointment, October 1, 2013 through August 25, 2014

Clinic	Average Number of Days
Psychiatry	23.6
Psychology	23.6
Primary Care	7.2
Gastroenterology	29.2
Orthopedics	46.3
Urology	58.7
Cardiology	73.2

Source: OIG analysis of VHA data

Note: The third next available appointment reflects the number of working days from the day care is sought until the third next available appointment. This is a measure of access to care that is commonly used by the private sector.

With respect to access for new patients, the vast majority of new patients seeking care with a psychiatrist or psychologist (90.3 percent) waited 30 days or less for an appointment. However, a lower percentage of patients seeking care through other clinics were able to obtain an appointment timely, as illustrated in Table 2.

⁴On May 22, 2014, the Secretary of VA announced a new initiative to reduce the number of veterans waiting 30 days or longer, referred to as the Accelerating Access to Care Initiative. As per the initiative, facilities will make a minimum of three attempts to contact any veteran patient new to VA care, or new to a particular clinic in a facility, who is scheduled for an appointment more than 30 days out or is currently on the Electronic Wait List. The previous 14-day MH access benchmark is no longer an active performance measure.

Table 2. Percentage of New Patients Who Waited for an Appointment Between 0 and 30 days, FY 2014

Specialty	Percentage of New Patients
MH	
Psychiatry	90.3
Psychology	90.3
Primary Care ^a	75.4
Cardiology	52.5
Gastroenterology	36.7
Orthopedics	61.0
Urology	27.9

Source: OIG analysis of VHA data

Note: The data presented in this table for primary care correspond to data for the internal medicine specialty only.

Issue 2: Factors that Affected Access to MH, Primary Care, and Selected Specialty Care

Numerous factors affected the timeliness of veterans' access to care at the EPVAHCS, including staffing, productivity, and clinic cancellations and no shows. These factors and their impact on access are described in detail below.

Staffing

Although the actual number of full-time equivalent (FTE) clinical providers may be sufficient to sustain timely access to care, we found that many of these providers dedicate only a portion of their time to direct patient care, particularly for MH. Among MH providers at the EPVAHCS, providers dedicated between 10 percent and 85 percent of their effort to non-direct patient care activities, as illustrated in Tables 3 and 4. All else held constant, extensive involvement of clinic providers in non-clinical activities can have a deleterious effect on access. (For case studies on the allocation of MH providers time, see Appendix A.)

Table 3. EPVAHCS Psychiatric Provider Total FTE, FTE Dedicated to Direct Patient Care, and Percentage of Time Dedicated to Direct Patient Care, as of September 19, 2014

Provider	Total FTE	FTE Direct Patient Care	Percentage of Time Dedicated to Direct Patient Care
NP 1	1	0.75	75.0
NP 2	1	0.82	82.0
NP 3	1	0.75	75.0
NP 4	1	0.79	79.0
MD 1•	1	0.1	10.0
MD 2	0.5	0.38	38.0
MD 3	1	0.85	85.0
MD 4	1	0.8	80.0
MD 5	1	0.75	75.0
MD 6	0.5	0.39	39.0
MD 7	1	0.85	85.0
MD 8	1	0.3	30.0
MD 9	1	0.78	78.0
MD 10	1	0.85	85.0
MD 11	1	0.85	85.0
Total	14	10.01	--

Source: EPVAHCS - Chief of Mental Health

Table 4. EPVAHCS Psychologist Provider Total FTE, FTE Dedicated to Direct Patient Care, and Percentage of Time Dedicated to Direct Patient Care, as of September 19, 2014

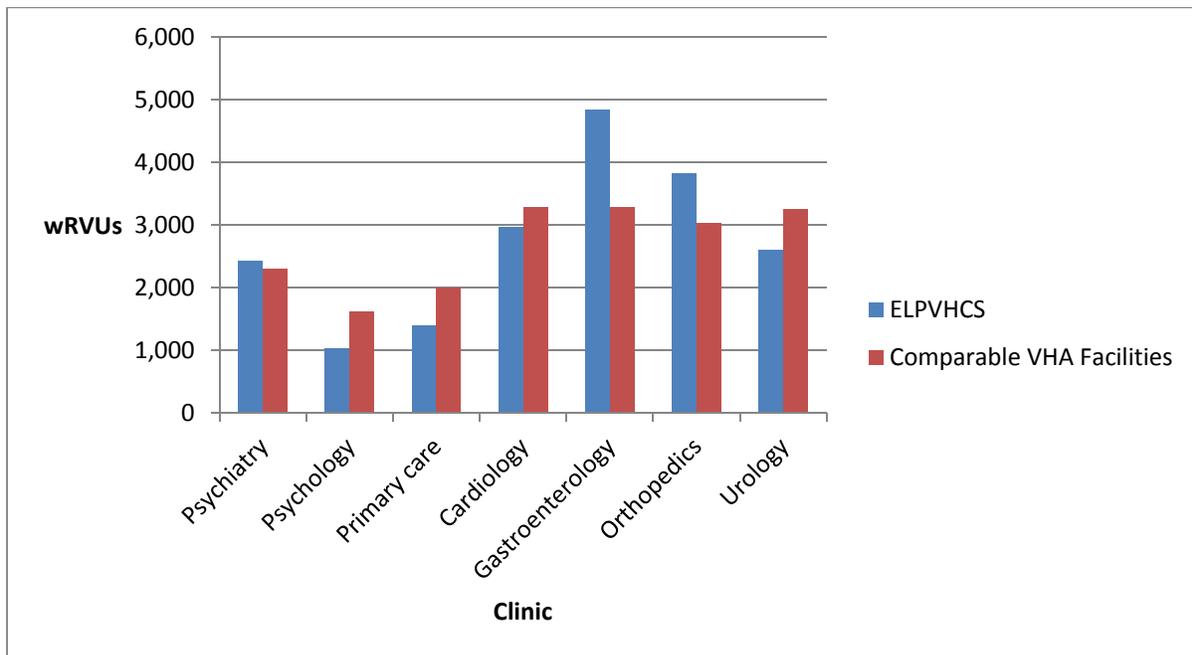
Provider	Total FTE	FTE Direct Patient Care	Percentage of Time Dedicated to Direct Patient Care
Psychologist 1	1	0.85	85
Psychologist 2*	1	0.6	60
Psychologist 3	1	0.85	85
Psychologist 4†	1	0.4	40
Psychologist 5**	1	0.1	10
Psychologist 6†	1	0.4	40
Psychologist 7***	1	0.70	70
Total	7	3.9	—

Source: EPVAHCS. *Evidence-Based Therapy Coordinator. **Suicide Prevention Coordinator. ***Prevention and Management of Disruptive Behavior Coordinator. †Supervisor.

Productivity

One factor affecting access at the EPVAHCS is provider productivity. This is an important factor because, to the extent that providers are not productive, access issues may persist despite sufficient numbers of providers and support staff. Physician productivity at the EPVAHCS is higher than that at comparable VHA facilities⁵ for psychiatry, gastroenterology, and orthopedics based on work relative value units (wRVUs), as depicted in Figure 1.⁶ In contrast, physician productivity at the EPVAHCS is lower than that at comparable VHA facilities for psychology, primary care, cardiology, and urology.

Figure 1: Comparison of Physician Productivity at EPVAHCS and Other Comparable VHA Facilities, by Clinic



Source: OIG Analysis of VHA data from April and July 2014

Low productivity among certain EPVAHCS clinics can be explained, at least in part, by the length of patient appointments, provider work that is not counted towards wRVUs (referred to as uncaptured workload), and data errors. These explanatory factors are explored further below.

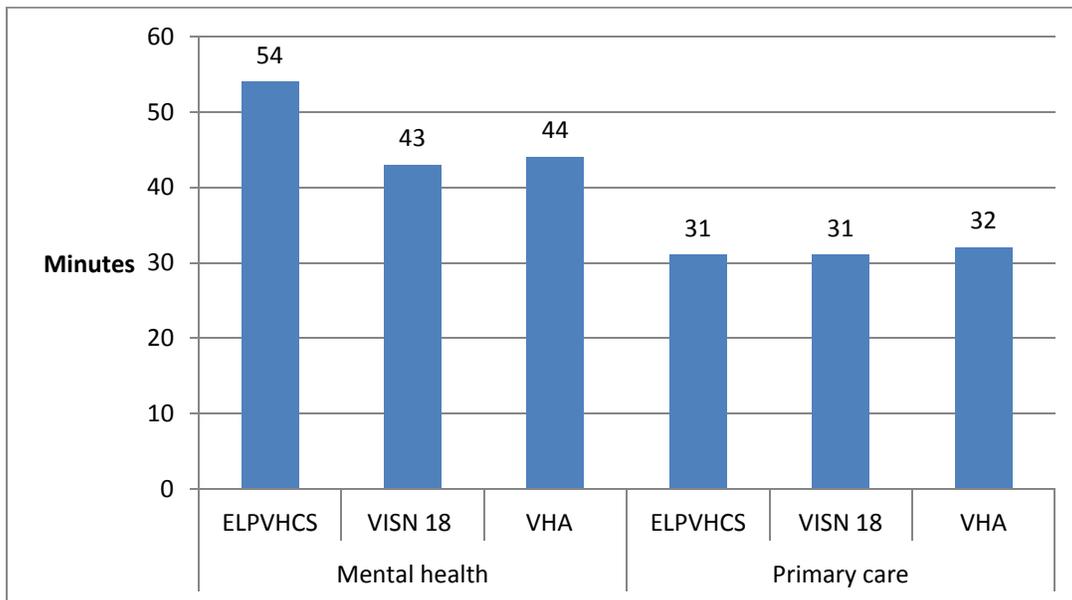
- Length of Patient Appointments. When providers spend a long time with patients, productivity will be reduced. At the EPVAHCS, MH providers are

⁵For the purposes of our analysis, we considered facilities that VHA assigned as “level 3” complexity as comparable to the EPVAHCS. VHA assigns facilities with level 1a-1c, 2, or 3 surgical complexity based on patient population served, clinical services offered, education and research complexity, and administrative complexity.

⁶RVUs is a commonly used measure of physician productivity that ranks resources used to provide each service, including physician’s work, the expenses of the physician’s practice, and professional liability insurance. Higher wRVUs indicates higher productivity; whereas, lower wRVUs indicate lower productivity.

allotted, on average, longer time with patients than MH providers at other facilities in the VISN or across VHA. (See Figure 2.) That is, EPVAHCS MH providers are allotted, on average, 54 minutes with patients compared to 43 minutes at all facilities in the VISN and 44 minutes at all facilities across VHA. In contrast, the amount of time EPVAHCS primary care providers are allotted with patients was comparable to the amount of time primary care providers in the VISN and across VHA spent with patients.

Figure 2. Comparison of Allotted Appointment Length for EPVAHCS, VISN 18, and VHA As of July 31, 2014, MH and Primary Care Clinics



Source: OIG analysis of VHA data

Longer appointment lengths can reflect appropriate care or ineffective clinical practices, depending on the context. For example, psychotherapy appointments by their nature are longer than psychiatry appointments, so the total number of patients who can be seen in a day would be less and productivity will be lower. In contrast, primary care appointments in clinics with insufficient support staff may last longer than they should because providers need to expend valuable appointment time to collect information that could have been collected by a technician or nurse prior to the visit with the provider.

- Uncaptured Workload.** EPVAHCS providers we interviewed told us that their productivity may appear artificially low because some of their workload is not captured by productivity measures. For example, services provided by an EPVAHCS cardiologist to EPVAHCS patients at William Beaumont Army Medical Center (WBAMC) or as inpatients at the New Mexico VA Health Care System is not captured as EPVAHCS workload. Primary care providers we interviewed told us that the volume of non-credit workload was “astronomical.” One long-time provider reported seeing 18 to 23 patients on average per day when he first came to the facility 19 years ago. The provider expressed the perception that as a consequence of over-emphasis on metrics and “dotting I’s and T’s” his

productivity has steadily decreased over time. The provider pointed to secure messaging as an example. Since implementation over the past year, the provider reports receiving between 50 and 100 secure messages from patients per day for which a response is expected.

- **Data Errors.** EPVAHCS providers we interviewed also told us that their productivity may appear low because of data errors. In particular, psychology and cardiology providers we interviewed expressed concerns that the algorithms (referred to as labor mapping) to determine the direct care portion of their time were inaccurate. Consequently, their productivity appeared artificially low. For example, EPVAHCS psychologist total FTE dedicated to direct patient care is 3.9 FTE. However, psychologists had been labor mapped for 4.98 total direct patient care FTE, a 27 percent difference. In particular, one psychologist is mapped to 0.85 direct patient care FTE but provides 0.1 direct patient care because the provider is also the facility’s full-time suicide prevention coordinator. As previously discussed, a cardiologist sub-specialist is mapped to EPVAHCS as 0.94 direct care FTE, which does not reflect that almost half of the provider’s direct patient care workload is performed for EPVAHCS patients at WBAMC and the Albuquerque VAMC.

Additional information about productivity at the EPVAHCS and the impact on access is presented in Appendix B.

Cancelled Appointments and “No Shows”

The rate of cancelled appointments and no shows at the EPVAHCS negatively impacts veterans’ access to care, since appointment slots that are filled by veterans who ultimately will not be present to receive care are not available to other veterans who are trying to make an appointment. For example, as illustrated in Table 5, the cancelled by clinic before appointment rate exceeds the VISN and VHA rates. Nearly 12 percent of primary care appointments are no shows. Although that rate is comparable to the rate across VHA and VISN 18, it presents an important challenge for ensuring timely access.

Table 5. Cancelled Appointment and No Show Rates for EPVAHCS, VISN 18, and VHA Primary Care Clinics as of July 31, 2014

Entity	Cancelled by Clinic Before Appointment Rate	Cancelled by Patient Before Appointment Rate	No Show Rate
EPVAHCS	13.07%	10.0%	11.92%
VISN 18	10.73%	9.17%	11.46%
VHA	9.03%	11.3%	11.32%

Source: VHA System’s Redesign, Clinic Access Index

Other Management Challenges

VHA program office and EPVAHCS leadership as well as EPVAHCS clinical and administrative staff described several other key issues and management challenges that contribute to access issues. For a discussion of these issues and challenges, see Appendix C.

Conclusions

We substantiated the concern that many veterans at the EPVAHCS faced challenges accessing care timely. We found that this was particularly true among patients who were new to the System. Based on our review of VHA and EPVAHCS data and interviews with pertinent leaders and clinical and administrative staff, we found that numerous factors affected the timeliness of veterans' access to care at the EPVAHCS, including staffing, productivity, and clinic cancellations and no shows. We explored these factors, as well as other key issues and management challenges, and their impact on access.

Efforts to improve access and productivity at the EPVAHCS should consider the factors we described in this report, both individually and in combination.

We made 11 recommendations.

Recommendations

1. We recommended that the Facility Director review clinic productivity and implement a plan to enhance productivity in those clinics for which productivity is an issue.
2. We recommended the Facility Director ensure clinical departments accurately capture provider workload.
3. We recommended the Facility Director direct clinical departments to review labor mapping to ensure the labor mapping is up to date and accurately reflects the percentage of provider time allocated to direct patient care.
4. We recommended the Facility Director review the quadrants into which mental health, primary care, and specialty care clinics appear on the VHA Specialty Productivity-Access Report and Quadrant (SPARQ) tool, and evaluate and address underlying factors.
5. We recommended the Facility Director take measures to promote alignment of organizational structure with clinic centered accountability, goals, and expectations.
6. We recommended the Facility Director revise policy and/or processes to facilitate primary care Patient Aligned Care Team (PACT) operation and support PACT model workflow and clinic-wide coordination of care.

7. We recommended the Facility Director identify specialties particularly vulnerable to loss of a provider and explore contingency plans to potentially mitigate the impact of provider loss on clinic disruption.
8. We recommended the Facility Director take measures to promote non-provider to provider communication within mental health, primary care, and specialty clinics.
9. We recommended the Facility Director consider inter-service agreements between primary care and specialty care clinics.
10. We recommended the Facility Director direct MH clinic leadership to evaluate access and patient engagement for specific types of outpatient mental health services, including individual psychotherapy and intensive substance use treatment, in order to provide a more encompassing picture of MH access.
11. We recommended the Facility Director provide a quarterly update on facility efforts to revise outpatient MH clinic processes to promote greater continuity of care through the regular outpatient MH clinic and to better focus the walk-in clinic toward serving those in need of walk-in care.

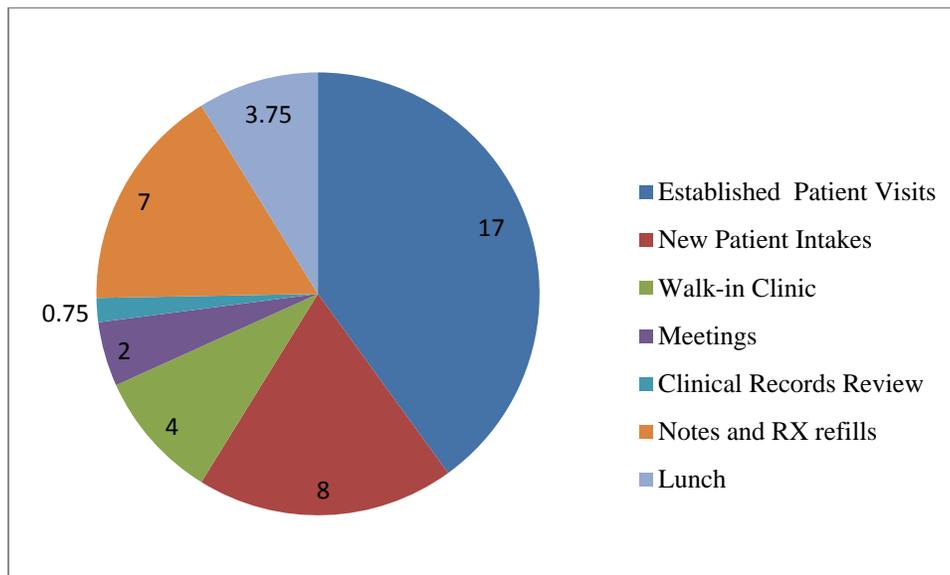
Case Studies of Schedules and Impact on Access

To understand the impact of staff schedules on access to care, we examined clinic provider profiles/schedules for select MH providers for different disciplines (psychiatry, psychology, social work, and addiction therapist).

Case Study 1

This first case study presents information on the clinic profile for a full-time psychiatrist with 85 percent of effort dedicated to direct patient care. (See figure 3.)

Figure 3. Weekly Allocation of a Sample Psychiatrist’s Clinic Time



Source: OIG analysis of EPVAHCS data.

This provider’s profile reflected 36.75 patient care hours/42.5 hours=0.86 direct care FTE. Overall, based on 60 minute intakes and 30 minute established patient appointment blocks, this schedule theoretically could provide for a weekly maximum of:

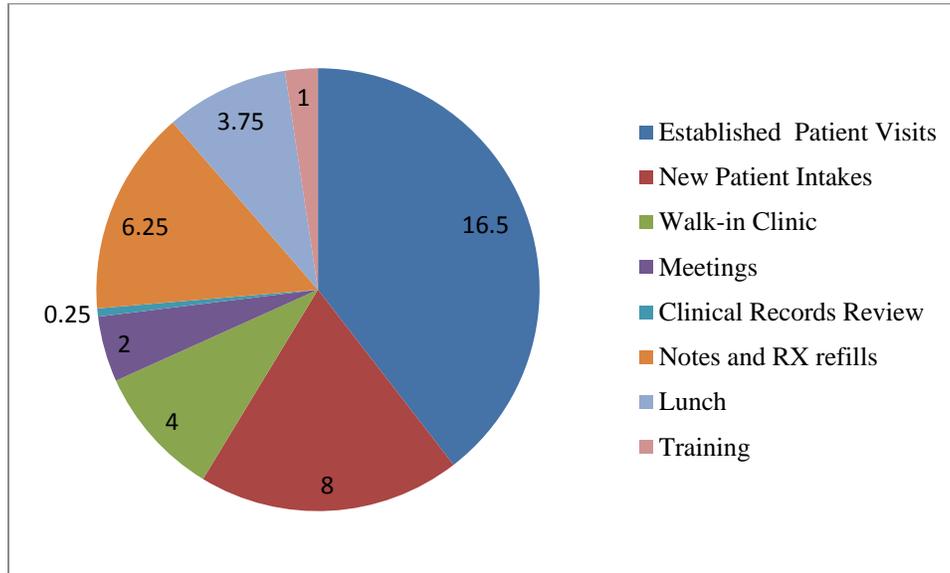
- 8 new patient intakes
- Up to 34 scheduled established patient visits per week
- Walk-in hours would provide approximately between 4 and 8 additional patient visits depending on the nature of the presenting problem (for example, new versus patient known to MH clinic; urgent need requiring admission versus stable patient experiencing uncomplicated medication side effect).

At a maximum, this provider could therefore see 50 encounters per week. If the missed opportunity (no show) rate is 0, this would provide up to 10 patient encounters per provider per day or 11.8 encounters per FTE devoted to direct patient care per day.

Case Study 2

The second case study presents information on the clinic profile for a MH nurse practitioner's profile with 75 percent of effort allocated to direct patient care. (See Figure 4.)

Figure 4. Weekly Allocation of a Sample MH Nurse Practitioner's Clinic Time



Source: OIG analysis of EPVAHCS data

The nurse practitioner profile includes 35/41.76 hours = 0.84 direct clinical hours. Assuming a missed opportunity rate = 0, at a maximum this provider could perform 49 patient encounters per week which equates to 9.8 encounters per provider per day or 11.66 encounters per FTE devoted to direct patient care per day.

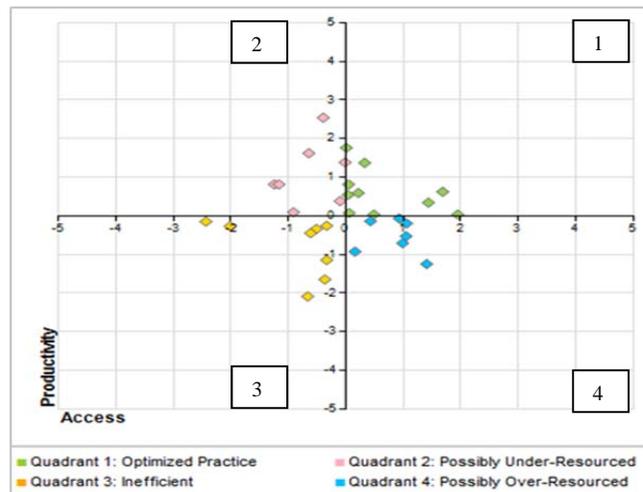
With the actual missed opportunity rate factored in, this would equate to 8.06 encounters per provider per day or 9.6 encounters per FTE devoted to direct patient care per day.

Productivity

VHA’s Office of Operational Analytics and Reporting, Office of Productivity, Efficiency, and Staffing’s (OPES) Specialty Productivity-Access Report and Quadrant (SPARQ) tool is intended to assist VHA and facility leadership in evaluating specialty productivity, access, staffing, and efficiency. The SPARQ tool, which is illustrated in Figure 5 below, provides a quadrant-based action grid that provides a scaled importance and performance of access and productivity as attributes on the two axes of the grid. Facilities are assigned performance in 1 of 4 quadrants, which can be interpreted per OPES as follows:

- Quadrant 1: Access and productivity above the mean is thought to reflect optimal practice (assuming access measures accurately reflect patient access to care).
- Quadrant 2: Productivity above the mean but access below the mean may indicate that specialty is under-resourced or the demand for and/or utilization of specialty resources is not appropriately managed.
- Quadrant 3: Productivity and access below the mean may indicate that the service is inefficient.
- Quadrant 4: Productivity below the mean and access above the mean may indicate that the specialty service is over-resourced and/or the demand/utilization for in-house specialty services is constrained.

Figure 5: SPARQ Tool



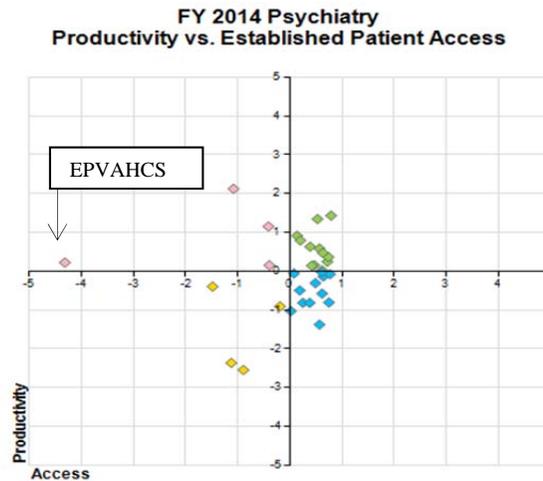
Source: VHA OPES

To illustrate the SPARQ tool, we provide the information for psychiatry, psychology, and primary care. The SPARQ tool is also available for the four specialties included in our review.

Psychiatry

EPVAHCS psychiatry services graphs in quadrant 2 for productivity versus established patient access, possibly indicating that psychiatry may be understaffed, that demand is not appropriately managed or that resources are not being effectively deployed to sufficiently address demand. (See Figure 6.)

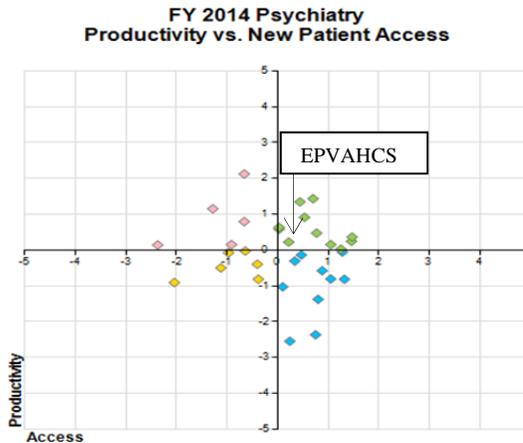
Figure 6. SPARQ Tool for Psychiatry for Level 3 VHA Facilities, Productivity Versus Established Patient Access



Source: VHA OPES

EPVAHCS psychiatry services graphs near the mean for comparable VHA facilities, which is in quadrant I (a green diamond), for productivity versus new patient access. (See Figure 7.)

Figure 7. SPARQ Tool for Psychiatry for Level 3 VHA Facilities, Productivity Versus New Patient Access

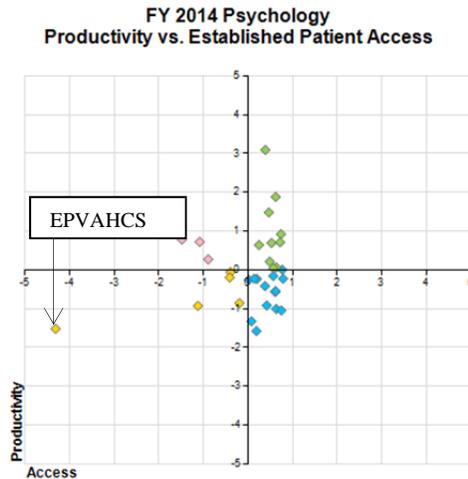


Source: VHA OPES

Psychology

For established patient access v. productivity, EPVAHCS graphs to quadrant 3 indicating that the service may be inefficient. (See Figure 8.)

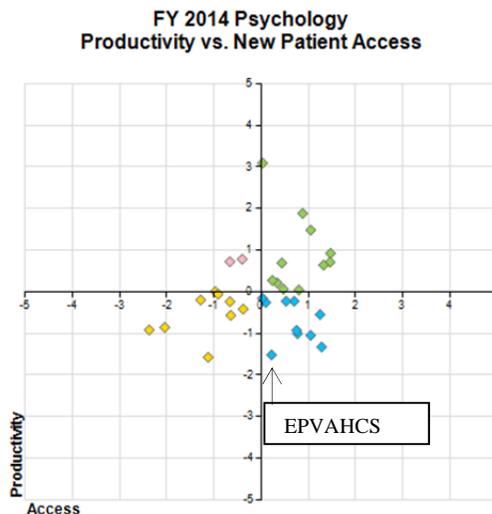
Figure 8. SPARQ Tool for Psychology for Level 3 VHA Facilities, Productivity vs. Established Patient Access



Source: VHA data

EPVAHCS psychology services graph to quadrant 4 for new patient access versus productivity indicating that either the specialty is over-resourced or the demand/utilization is internally constrained. For example, patients are not interested in the service, are not being referred to the service or certain psychology services are not available. (See Figure 9.)

Figure 9. SPARQ Tool for Psychology for Level 3 VHA Facilities, Productivity Versus New Patient Access

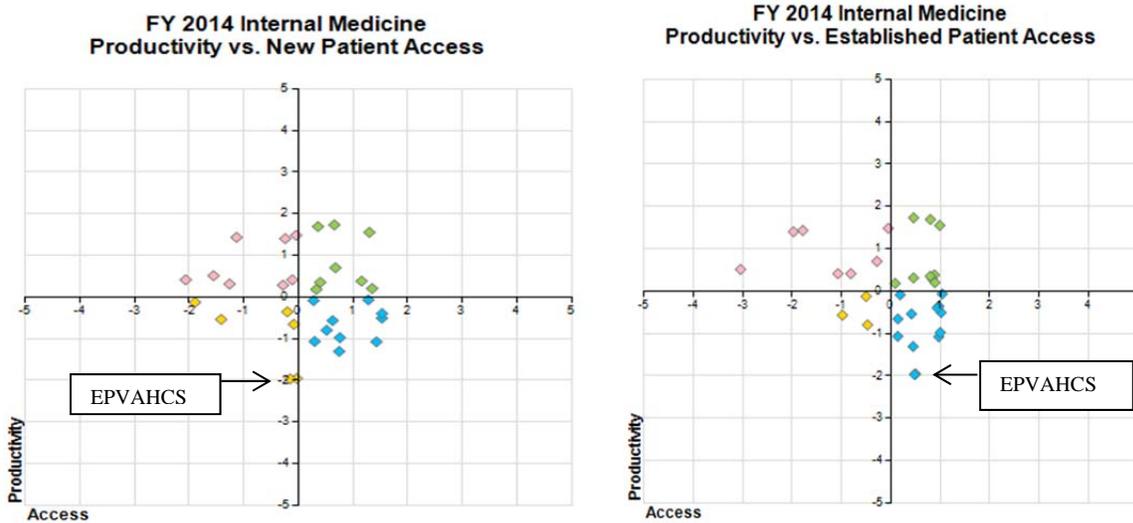


Source: VHA data.

Primary Care

Figures 10 below graphically portray the SPARQ tool for productivity versus established patient access and new patient access for internal medicine for FY 2014. The SPARQ data is not specific for primary care providers, as some internal medicine physicians work in internal medicine clinics other than primary care. However, the Office of Operational Analytics and Reporting told us the concordance between the data for internal medicine and primary care is approximately 80–85 percent and therefore a reasonable ballpark proxy.

Figure 10. SPARQ Tool for Internal Medicine for Level 3 VHA Facilities, Productivity Versus New Patient Access



Source: VHA OPES

For new patient appointments, the data falls barely into Quadrant III indicating the service may be inefficient. For established patient appointments, the data falls within Quadrant IV which may indicate that the specialty service is over-resourced and/or the demand/utilization for in-house specialty services is constrained.

Other Key Issues and Management Challenges

Based on our interviews with VHA program office leadership and ELPHCS leadership and clinical staff, we identified numerous factors that affected veterans' access to timely medical care, as summarized below.

Table 6. Key Issues and Management Challenges Described by Interviewees

Key Issues and Management Challenge	Description
Aligning provider incentives to promote increased productivity in addition to quality	Some private entities use a guaranteed base salary plus incentive based compensation for productivity, service quality, clinical quality, and patient satisfaction. We recognize that within the Federal human resource policy structures, effecting re-alignment may require a bonus incentive structure focused on a clinic or department's aggregate achievement of productivity, quality, and patient care experience goals rather than on achievement at the individual provider level. In addition, we recognize that an incentive based construct may require legislative action.
Aligning organizational structure to promote patient/clinic-centered accountability	Clinic function is dependent not only on front-line clinical providers but also on the other clinical and administrative members of the clinic team. An accountability structure in which each member of the team reports up a different silo with differing goals and expectations does not support broad ownership by all team members in achieving uniformity of clinic goals, improving outcomes, and the patient care experience.
Leadership engagement with patients and front-line staff	Although EPVAHCS have engaged in lengthy public town hall forums (including one that went into the late hours while the OIG was on-site) and are busy in their own right, the pro-active value of regular walks around the facility to engage patients and staff cannot be underscored. Additionally, this provides a hands-on opportunity to identify and/or address issues before they "bubble up," progressively view operations and change efforts over time, ask questions based on "in the trench observations," and to iteratively "feel the pulse" of patients and staff.

<p>Operationalizing PACT teams in practice (making PACT Teams Functional)</p>	<p>One intention of the PACT model is for clinical team members to work toward their highest level of license and for support members to facilitate freeing providers up for a greater level of face-to-face patient care. Another intention is to promote wellness and team-based coordination of care. Improving provider alignment and provider/team/support staff incentive and accountability structures may bolster true PACT model implementation. At the facility, one PACT team reportedly operates as intended; while the other PACT teams run less smoothly or with a workflow that runs counter to what is intended under a PACT model. Leadership is challenged with the opportunity to revise primary care clinic processes in order to support true team-based coordination of care (as opposed to a collection of team members running in separate directions) and the flow of work to its appropriate level of capability.</p>
<p>Re-visiting the specialist consultation process and non-captured primary care workload</p>	<p>Primary care providers and specialists describe a situation in which consults are frequently requested as a default in the face of increasing amounts of non-captured primary care clinician workload (e.g., secure messaging). Re-invigorating true PACT model deployment and promoting clinic centered accountability as previously discussed may help lessen some of the non-captured workload burden. Leadership may want to explore other innovative approaches to address the burden of non-captured workload.</p> <p>In terms of the specialty consult process, when a consult cannot be seen timely by a specialty service, the need for primary care providers to enter a second consult introduces the potential for patients to get lost in the shuffle in addition to creating duplication of effort. Leadership may want to re-visit a way to streamline and safeguard the process.</p>
<p>Provider deployment, recruitment, and contingency planning</p>	<p>For some of the specialties at the EPVAHCS, provider staffing is lean. The risk of service disruption with loss of a provider is something to be factored into staffing plans. For example, if the only cardiologist leaves, the impact would be significant. Leadership may want to identify vulnerable specialties where based on patient demand, provider availability, and difficulty recruiting a provider, contingency planning would be advisable. Contingency plans might include over-hiring for built-in flexibility or increasing ties to clinicians at the local medical school. At several VA medical facilities in locations with medical schools, several academic clinicians work part time at the VA and part time at the university hospital. Leadership might explore strengthening ties and utilization of shared clinical staff with</p>

	Texas Tech’s Medical School in El Paso.
Closely monitoring trends in primary care panel capacity growth and attrition	EPVAHCS primary care panels are at 95 percent capacity with more than 60 percent of providers at or above the target panel capacity. If the rate at which new patient appointments are requested (demand and rate of market penetration) exceeds panel attrition rates over the next few years, then over time, even if clinic efficiency or provider productivity increase the ability to accommodate new patients will become less as the percentage of available target panel capacity decreases (in the absence of changes in staffing). This would subsequently diminish new patient access. Leadership will need to watch these trends closely and address proactively, as indicated.
Elucidating access to specific types of MH services and therapies	Modes of MH care include medication management, intensive outpatient substance use services, group psychotherapy, and individual psychotherapy among others. VHA access measures for MH are an aggregated measure. Self-assessing access and patient engagement in treatment for each type of treatment modality or service (Diving Deeper into Types of MH Service Access) would provide EPVAHCS (or any VA) and MH leadership a more robust picture of MH access from the individual patient perspective and potential steps to take in-response.
Disjointed communication and clinic accountability structure	<p>A common theme heard from MH, primary care, and specialty clinicians focused on the need for improved non-provider to provider communication and changes in the present clinic accountability structure. One provider who had worked at other VA facilities commented “the MSA [medical scheduling assistant] issue is most critical...it’s organization, missed schedules, no communication...this is the only place I have seen support staff tell a service chief what they won’t do...first impressions make a difference, you want to put your best foot forward...to develop intra-clinic communication and integration you need accountability.”</p> <p>Several providers expressed the belief that the present accountability structure is based on the type of employee rather than on a clinic centered structure, which some of the providers were accustomed to when they worked in the private sector. Specifically, MSAs report up their Health Administrative Services chain, nursing reports up the nursing chain, and physicians up the physician chain with a lack of built-in mechanisms to support accountability to the clinic team, clinic function, and therefore ultimately to clinic patients.</p>

	<p>As a related aspect, with a few exceptions, the general sense was that from a communication and coordination standpoint, team members feel as if they are out of synch or running in different directions. Differing goals and expectations in each silo detract from clinic goals and uniformity.</p> <p>In addition, MSAs may rotate between clinics, which can detract from the day-to-day efficiency resulting from accrued knowledge and familiarity with clinic specific providers, processes, and PACT team functions.</p>
<p>“Unmanaged” specialty consult referrals and process inefficiency</p>	<p>Both primary care physicians and medical/surgical specialists identified this issue. Because primary care providers report being “swamped” with patient care and administrative burden, the default mode is to have a low threshold for sending patients who might otherwise have been managed in a primary care clinic for specialist care. For example, a patient with an abnormal TSH⁷ who otherwise might have been started on levothyroxine⁸ in primary care might instead be referred to endocrinology, or a patient calling the clinic with back pain might be sent for an orthopedics consult before getting x-rays and attempting to first examine the patient and assess and manage the problem in a primary care setting. As one surgical specialist described the situation, it’s the opposite of a managed care paradigm; because primary care is “swamped,” consults become “unmanaged care.”</p>
<p>Improving the balance between MH access and continuity of care</p>	<p>Facility MH and clinical leadership verbalized the need for and newly initiated efforts to realign balance between access to MH care and providing continuity of care. In recent years, the MH walk-in clinic has been over-utilized. “Everything is dumped into the walk-in clinic” instead of acting as a safety valve, it can <i>become</i> the clinic which disrupts continuity. The SPARQ data reflects a disparity between strained established patient access and new patient access. Patients spontaneously presenting to walk-in clinic for evaluation, patients recently discharged from inpatient hospitalization, and patients needing prescription refills, among others, in recent years have been referred to the</p>

⁷ Thyroid Stimulating Hormone—a hormone naturally produced by the pituitary gland after stimulation from Thyrotropin releasing hormone produced in the body’s hypothalamus. TSH then stimulates production of two thyroid hormones T3 and T4 which help regulate body metabolism. An elevated TSH level may indicate inadequate production/problems with the body’s innate ability to produce sufficient T3 and T4. Depending on clinical severity symptoms of hypothyroidism in adults may include fatigue, increased sensitivity to cold, unexplained weight gain, dry skin, thinning hair, hoarseness, impaired memory, and muscle weakness among others.

⁸ An important hormone naturally produced by the thyroid gland. Patients with hypothyroidism may be treated with oral levothyroxine medication.

	<p>walk-in clinic.</p> <p>The prevailing over-reliance on the walk-in clinic is thought to have arisen from not having had enough prescribing clinicians and an overemphasis on meeting new patient access measures at the expense of continuity of care. While the prevailing emphasis appropriately provides timely access for patients who may be acutely decompensating, strengthening processes to clinically prioritize utilization of the walk-in clinic and to provide timely routine MH care to non-urgent patients, would benefit both patients in need of walk-in care and those patients seeking ongoing continuity of care through their regular MH providers.</p> <p>In April, the facility brought on board a psychiatric director for the MH outpatient clinic. This clinician has been working to revise processes to re-orient the MH clinic toward being the MH clinic and the walk-in clinic toward serving those in need of walk-in care, including proposing different mechanisms by which to accommodate recently discharged patients and patients needing prescription refills.</p>
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VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: November 19, 2014

From: Acting Network Director, VISN 18 (10N18)

Subj: Healthcare Inspection—An Analysis of Mental Health, Primary Care and Specialty Care Productivity and Related Issues, El Paso VA Health Care System, El Paso, Texas

To: Under Secretary for Health (10N)

1. I have reviewed and concur with findings and recommendations 1 through 8, 10 and 11 in the report of the Healthcare Inspection – An Analysis of Mental Health, Primary Care and Specialty Care Productivity and Related Issues, El Paso VA Health Care System, El Paso VA Health Care System, El Paso, Texas. I do not concur with recommendation 9.
2. If you have any questions or concerns, please contact Jennifer Kubiak, Quality Management Officer, VISN 18, at 480-397-2781.

(original signed by:)

Kathleen R. Fogarty
Acting Network Director

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: November 19, 2014

From: Director, El Paso VA Health Care System (756/00)

Subj: Healthcare Inspection—An Analysis of Mental Health, Primary Care and Specialty Care Productivity and Related Issues, El Paso VA Health Care System, El Paso, Texas

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

1. I have reviewed and concur with findings and recommendations 1 through 8, 10 and 11 in the report of the Healthcare Inspection – An Analysis of Mental Health, Primary Care and Specialty Care Productivity and Related Issues, El Paso VA Health Care System, El Paso VA Health Care System, El Paso, Texas. I do not concur with recommendation 9.
2. Corrective action plans have been established, with some already implemented, and target completion dates have been set for the recommendations as detailed in the attached report.

(original signed by:)

Peter Dancy, FACHE
Acting 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 Facility Director review clinic productivity and implement a plan to enhance productivity in those clinics for which productivity is an issue.

Concur

Target date for completion: June 30, 2015

Facility response: A comprehensive review of clinical productivity will be completed to identify and correct issues resulting in low productivity. A plan for clinics with low productivity will be developed and implemented. The action plan will be reported monthly to the EPVAHCS Executive Health Care Council (EHCC) through the Clinical Executive Board (CEB) until improvements have been achieved and sustained.

Recommendation 2. We recommended that the Facility Director ensure clinical departments accurately capture provider workload.

Concur

Target date for completion: June 30, 2015

Facility response: Clinic profiles, VistA clinic utilization statistical summary report (CUSS), SPARQ reports, clinical documentation, provider productivity and labor mapping will be reviewed to ensure accurate provider workload capture. Clinical supervisors of clinics not accurately capturing provider workload will develop and implement action plans. The action plans will be reported monthly to the EPVAHCS EHCC through the CEB until improvements have been achieved and sustained.

Recommendation 3. We recommended that the Facility Director direct clinical departments to review labor mapping to ensure the labor mapping is up to date and accurately reflects the percentage of provider time allocated to direct patient care.

Concur

Target date for completion: June 30, 2015

Facility response: Labor mapping of all clinical services will be reviewed and certified by the respective Quadrad member monthly until improvements are achieved and sustained.

1. Beginning December 1, 2014, labor mapping training and a reference guide will be provided to all clinical supervisors and respective Quadrad members by facility Data Support Service. Annual training will be required and assigned in Talent Management Service to every clinical supervisor.

2. Beginning December 1, 2014, labor mapping certification will be reported to and signed off by clinical Quadrad leaders for oversight until labor mapping reflects improvements in clinics with low productivity. Supervisors with low productivity clinics will develop and implement action plans. The action plans will be reported monthly to the EPVAHCS EHCC through CEB until improvements have been achieved and sustained.

Recommendation 4. We recommended that the Facility Director review the quadrants into which mental health, primary care, and specialty care clinics appear on the VHA SPARQ tool, and evaluate and address underlying factors.

Concur

Target date for completion: June 30, 2015

Facility response: A review of VHA SPARQ, in addition to other VHA tools, is in progress and will be completed for Mental Health, Primary Care, and Specialty Care clinics. Underlying factors which may be impacting quadrant placement will be identified and a corrective action plan will be implemented. The action plan will be reported monthly to the EPVAHCS EHCC through CEB until improvements have been achieved and sustained.

Recommendation 5. We recommended that the Facility Director take measures to promote alignment of organizational structure with clinic centered accountability, goals, and expectations.

Concur

Target date for completion: June 30, 2015

Facility response:

1. In September 2014 there was a realignment of the organizational structure that included changes to Primary Care (PC) leadership including Nursing, Medicine, and Health Administration Services. Non-VA Care services were realigned under the Chief of Staff.

2. The Quadrad will identify specific goals and expectations for FY15 performance plans and supervisors will be rated on the overall success of the clinics and their ability to work as a team to achieve those goals and expectations.

Recommendation 6. We recommended that the Facility Director revise policy and/or processes to facilitate primary care PACT operation, and support PACT model workflow and intra-clinic coordination of care.

Concur

Target date for completion: September 30, 2015

Facility response: EPVAHCS PACT leads are executing an action plan that was implemented with input from VHA PACT assist team. This action plan is being reviewed weekly by EPVAHCS PACT leads and executive leadership to ensure ongoing progress. Changes have already been implemented and include daily huddles and modifying the consult process for Non-VA Coordinated Care to reduce duplication of work for providers. PACT leads will report monthly the status of action plans in EPVAHCS EHCC for oversight until PACT implementation measures have been met and sustained.

Recommendation 7. We recommended that the Facility Director identify specialties particularly vulnerable to loss of a provider and explore contingency plans to potentially mitigate the impact of provider loss on clinic disruption.

Concur

Target date for completion: June 30, 2015

Facility response:

1. Additional FTEE have already been approved for cardiology, dermatology, neurology, optometry, and ophthalmology and are in various stages of the recruitment process. Vacancies and status of recruitment will be a recurring agenda item in Resources Committee and will be reported monthly to the EPVAHCS EHCC.
2. Supervisors of specialty clinics with challenges meeting workload demands will develop contingency plans for expanding capacity to include: telehealth modalities, extended hours, and partnership with DoD, use of Non-VA Coordinated Care and Choice Act. The contingency plans will be reported monthly to the EPVAHCS EHCC.

Recommendation 8. We recommended that the Facility Director take measures to promote non-provider to provider communication within mental health, primary care, and specialty clinics.

Concur

Target date for completion: June 30, 2015

Facility response: Beginning December 2014, the Quadrad, clinical and administrative supervisors will conduct combined team building within the mental health, primary care

and specialty clinic on a monthly basis. An action plan will be developed by each supervisor group for their areas on how they will promote collaboration and communication. Action plans will be reported monthly by the Quadrad in EPVAHCS EHCC.

Recommendation 9. We recommended that the Facility Director consider inter-service agreements between primary care and specialty care clinics.

Non-Concur

Target date for completion: Not applicable.

Facility response: Service agreements were in place at the time of the OIG visit and are posted on the intranet. The most recent revision to these plans were communicated to primary and specialty care clinics on March 7, 2014.

Recommendation 10. We recommended that the Facility Director direct MH clinic leadership to evaluate access and patient engagement for specific types of outpatient mental health services, including individual psychotherapy and intensive substance use treatment, in order to provide a more encompassing picture of MH access.

Concur

Target date for completion: June 30, 2015

Facility response: EPVAHCS developed a comprehensive action plan with input from The Office of Mental Health Operations (OMHO). This action plan consists of actions to optimize MH services and access, including individual psychotherapy and intensive substance use treatment.

The action plan will be reported monthly to EPVAHCS EHCC through CEB until improvements have been achieved and sustained.

Recommendation 11. We recommended that the Facility Director provide a quarterly update on facility efforts to revise outpatient MH clinic processes to promote greater continuity of care through the regular outpatient MH clinic and to better focus the walk-in clinic toward serving those in need of walk-in care.

Concur

Target date for completion: June 30, 2015

Facility response: Changes implemented during the last year to address appropriate usage of the walk-in clinic include the following:

- Increased utilization of fee-based care to address patients that cannot receive an initial appointment with a provider within 30 days.
- Reviewing wait times to assess access.

- Creation of a MH consult team, which includes a 24 hour review and Veteran contact to minimize wait time after initial request for MH care.
- Reconfiguring the walk-in coverage schedule in order to ensure appropriate staffing levels within the walk-in clinic.
- Filling open positions and approval of additional positions to meet national staffing level recommendations.
- Education of Primary Care teams, increased usage of PCMHI program, and inter service agreement between Primary Care and MHS.

Since October 2, 2014 questions about care and medication refill needs are routed to the assigned attending provider for continuity of care, and nurses are managing phone call requests diminishing the need for walk-in clinic utilization. On October 10, 2014, a 6 month review (April 2014 - September 2014) of all (1765) patients seen in the walk-in clinic was performed. Only 11.9% used the walk-in clinic for crisis situations. The analysis of the data will be used in a performance improvement project in efforts to optimize appropriate use of the walk-in clinic.

These changes are actions which are being followed as part of the comprehensive MHS action plan. The action plan will be reported monthly to the EPVAHCS EHCC through CEB until improvements have been achieved and sustained. Quarterly updates will be provided to the Network.

OIG Contact and Staff Acknowledgments

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