Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Denial of After-Hours Care at the VA Central Iowa Health Care System's Knoxville Division Knoxville, Iowa

Report No. 09-00524-177 **July 28, 2009**

VA Office of Inspector General
Washington, DC 20420

Executive Summary

The purpose of the inspection was to determine the validity of allegations that veterans who attempt to access care after 4:30 p.m. at the VA Central Iowa Health Care System's Knoxville Division (KD) are being denied care. A complainant provided examples of three veterans who were allegedly denied care.

We did not substantiate that the three veterans were denied care. The KD has not provided emergent or urgent care services since 1997. The system provided notice to all patients and stakeholders that, effective March 1, 2008, the hours of operation of the KD's Building 1 (administrative building) will be Monday through Friday, 7:00 a.m. to 4:30 p.m. Patients with emergent or urgent care needs were reminded to go to the nearest community emergency room or dial 911. The system established an interdisciplinary transition committee to identify and address issues related to the change in operating hours. These included plans regarding safety, alarms, access, and establishing policy and procedures.

Despite the information that was communicated to employees regarding the modified hours for Building 1 at the KD and the new procedures that were being implemented, we found that a number of employees did not fully understand the new procedures, their roles, or the roles of other employees. We also determined that the system did not have a policy to define how emergencies occurring on VA grounds would be managed.

We recommended that the System Director establish mechanisms to ensure that all employees who might have to deal with medical emergencies and veterans seeking care after hours at the KD have the necessary information, clear guidance, and instruction. We also recommended that a policy be established to address the response to and management of emergencies which occur on VA grounds.

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

TO: Director, VA Midwest Health Care Network (10N23)

SUBJECT: Healthcare Inspection – Alleged Denial of After-Hours Care at the VA Central Iowa Health Care System's Knoxville Division, Knoxville, Iowa

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections, reviewed allegations regarding the denial of care to veterans seeking treatment after administrative hours at the Knoxville Division (KD) of the VA Central Iowa Health Care System (the system). The purpose of the inspection was to determine the validity of the allegations.

Background

The system consists of two divisions, located in Des Moines and Knoxville, Iowa. The Des Moines Division (DMD) provides primary care, medical, surgical, psychiatric, substance abuse, and home care services. The Knoxville Division (KD) provides rehabilitation, mental health, and community living center care and is a referral center for acute and long-term mental health patients. The system is academically affiliated with University of Iowa's Carver College of Medicine; Des Moines Area Medical Education Consortium, Incorporated; and Des Moines University.

A complainant alleged that veterans who attempt to seek care at the KD after 4:30 p.m. are being turned away. The complainant provided examples of three veterans who attempted to access care but were allegedly denied care.

The system has been making changes at the DMD and KD as part of the transition process for implementing the plans which resulted from the VA Capital Asset Realignment for Enhanced Services (CARES) project. The purpose of the multi-phase and multi-year CARES project was to analyze the 23 Veterans Integrated Service Networks (VISNs) in order to realign its health care facilities with the projected locations and needs of veterans into 2010. The goal was to develop a national CARES plan. The plan for the system included the construction of a new building for inpatients at the DMD. Once this new building is ready for use, the plan is to treat all of the system's

inpatients at the DMD. This will result in transferring inpatients from the KD to the DMD. The final plan is to have a community based outpatient clinic in Knoxville. Knoxville is approximately 37 miles from Des Moines.

Implementation of the CARES plan is complex and involves transition planning and phasing in numerous changes over a long time period. Effective March 1, 2008, the system made another change in support of implementing the CARES plan. The hours of operation for Building 1 (administrative building) at the KD were modified to 7:00 a.m. to 4:30 p.m., Monday through Friday (excluding Federal holidays). This change also involved reducing onsite staff coverage at KD after 4:30 p.m., including the Administrative Officer of the Day (AOD). Although emergent or urgent care services had not been provided at KD since 1997, prior to this change, patients were seen as walk-ins 24 hours per day, 7 days per week.

In order to prepare for this change, a transition committee was established to identify and address issues including safety, alarms, access, and policy and procedures. This interdisciplinary committee was led by the Business Office Manager and had 26 members including 2 American Federation of Government Employees (union) representatives. The committee focused on numerous issues including publicizing this change to patients, staff, and stakeholders. A letter, dated January, 28, 2008, was sent to all patients by the System Director. It stated, "Effective March 1, 2008, VA Central Iowa Health Care System, Knoxville campus will be changing the hours of operation for Building 1 (administrative building). The new hours will be Monday – Friday 7:00 a.m. to 4:30 p.m. for outpatient appointments. The Knoxville campus has not provided emergency care since 1997. We want to ensure you receive the most efficient and effective care available. If you have an emergency need, please go to your nearest emergency room or dial 911." The letter provided contact information for billing questions, as well as the names and telephone numbers of the patient advocates to contact for questions about the change. Additionally, the letter included the telephone number for the VA nurse advice line, available 24 hours per day. On February 5, 2008, the System Director sent an e-mail message to all system staff that contained much of the same information.

The System Director sent another letter, dated February 13, 2008, to patients advising them again of this change. With the exception of the following, the contents of the second letter were the same as the first: "To ensure all patients are notified of the upcoming hour change, it is necessary that we send out this second notification. If you have previously received this letter, please disregard. If not, please be advised of the information below." In addition to these mailings, the system created a news release that was sent to area newspapers.

> Effective March 1, 2008, VA Central Iowa Health Care System, Knoxville campus will be changing the hours of operation for Building 1

(administrative building). The new hours will be Monday – Friday 7:00 a.m. to 4:30 p.m. for outpatient appointments. The Knoxville campus has not provided emergency care since 1997. We want to ensure veterans receive the most efficient and effective care available. We have mailed a letter to veterans notifying them of this change. Veterans in need of emergency care are encouraged to dial 911 or go to their nearest emergency room." This e-mail also stated that a team had been formed to manage this transition. Information about the transition was a topic of discussion at employees' town hall meetings. Additionally, the transition committee determined that each service chief would be responsible for training their respective staff on the new process.

Scope and Methodology

We reviewed AOD logs, uniform offense reports (UORs), e-mail messages, and medical records related to the three identified patient episodes. We conducted a site visit on December 8–9, 2008, and interviewed managers and employees.

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

Case Summaries

Patient 1

The patient was in his mid-60s at the time of the event. On a Thursday in the fall of 2008, at 2:24 p.m., the patient telephoned the DMD. The nurse who took the call documented that the patient "sounded intoxicated" and reported having a stroke the prior evening, having swollen legs and feet, and "was dying." The nurse documented instructing the patient to contact Fire/Rescue (local ambulance service). The patient agreed to do this and ended the telephone call. At 3:14 p.m., the patient called the local ambulance service and complained of a "broken foot." At 3:20 p.m., the ambulance arrived at the patient's home. The patient was found lying in bed, reported "having too much to drink," and having injured the right foot due to a fall. The patient reported not taking currently prescribed medications. The ambulance staff documented edema in both feet and discoloration on top of the patient's right foot. Staff applied a splint to the patient's right foot and monitored vital signs, and the patient was transported by ambulance to the Knoxville Area Community Hospital (KACH)[i1] emergency room (ER), arriving at 3:45 p.m. At the KACH ER, the patient reported having fallen during the previous night, although did not remember doing so. The patient complained of pain in the right leg and shortness of breath. The patient reported not taking currently prescribed

[1] Knoxville Area Community Hospital is a non-VA facility.

medications "for 2 or 3 days." The patient's friend reported that the patient had been consuming alcohol for 2 days. An x-ray was taken and read, and the patient was given a dose of one of the currently prescribed medications that the patient reported not taking, a diuretic (water pill). At 5:42 p.m., that same Thursday, the patient was discharged home, and the friend provided transportation. The discharge diagnosis was contusion, right tibia; and it was noted that the patient was stable and "still intoxicated on discharge." The patient's discharge instructions included taking Tylenol every 6 hours as needed for pain and taking all of the currently prescribed medications as directed.

Later that same Thursday, at 6:10 p.m., the VA Police received a telephone call from a KD employee who reported observing the patient without shoes outside Building 67 on the VA grounds. The employee was concerned that the patient may be at risk due to the weather. Officers documented in the UOR that the patient was brought to the KD in a vehicle by a friend. An officer responded, found the patient outside the smoking shelter, and observed that the patient had bare feet and a torn right pant leg. The officer documented in the UOR that both of the patient's feet were "extremely swollen," he was complaining of pain, and that the patient reported having a recent stroke and being released from the KACH "a few days prior." A second officer arrived at the scene, and the patient reported that he needed help and that he had been told by the "area hospital" to go to the VA. One of the officers called the nursing supervisor and described the patient's situation and need for medical attention. The nursing supervisor told the officer that VA Police needed to call the Knoxville Police Department to have the patient escorted to the KACH to be seen, since it was then after administrative hours. The officers encouraged the patient to be seen at the KACH and to tell employees in the KACH ER to make arrangments for him to be evaluated at the DMD. The patient walked to the vehicle, and the friend told officers of his intent to talk the patient into going to the KACH ER.

On Friday, at 11:35 a.m., the patient was picked up by ambulance from the patient's hotel room and transported to the KACH. The patient arrived at the KACH at 12 noon and complained of shortness of breath and fluid accumulation in the feet. At 1:25 p.m., the system's AOD received a telephone request from a provider at the KACH to transfer the patient. The patient's medical problems, as reported to the AOD, included shortness of breath, a history of tuberculosis, and the need to rule out pulmonary embolism. The request for transfer was accepted, and the ambulance was arranged and paid for by the system. The patient arrived by ambulance at the DMD at 4:09 p.m. and was evaluated in the ER. The ambulance staff stated that the patient could no longer stay in the hotel room because of non-payment and is now possibly homeless. The ER physician documented that they ruled out an acute cardiopulmonary event, that the patient had emphysematous congestive obstructive pulmonary disease[2] and that the patient was now homeless. The plan was for the patient to be transported by cab to a shelter in Des Moines. At

[2] A long-term, progressive disease of the lung that primarily causes shortness of breath.

8:20 p.m., the patient left the DMD ER. After screening at the shelter, the patient was denied lodging due to legal issues. The patient was also complaining of nausea and vomiting. The patient was picked up by ambulance at the shelter and returned to the DMD ER, arriving at 9:40 p.m. The patient was placed in an ER examination room, and documentation states that the patient was walking in the hallway with normal gait and wearing shoes and socks. The patient reported a pain score of 10 (10 being the highest level of pain). At 9:56 p.m., electrocardiogram results were found to be normal, and there was no evidence of acute injury or ischemia (restricted blood flow). The provider opted to admit the patient to unit 3BM (inpatient medicine unit) at the DMD. One week later on a Friday, the patient was discharged to follow-up regarding the legal issues with the assigned probation officer.

Patient 2

The patient was in his early 40s at the time of the event. On a Friday in the late fall of 2008, at 8:00 p.m., the patient walked to the KD, telephoned VA Police, reported being outside Building 1, and requested admission. One of the officers contacted the nursing supervisor, while a second officer went to meet the patient at Building 1. The officer reported to the nursing supervisor that the patient was in front of Building 1 seeking treatment, and the officer requested that the supervisor and Medical Officer of the Day (MOD) see the patient. The nursing supervisor informed the officer that the patient would need to go to the KACH for evaluation. The nursing supervisor also stated that a MOD was not scheduled to be on duty at that time and that the MOD would not arrive until approximately 9:30 p.m. The officers then advised the patient to go to the KACH ER for evaluation. The patient reported to the officers that the medications to control his mental illness "might not be working well together." The patient reported wanting to come to the hospital "for a few days to have it taken care of before the situation got out of hand." The patient denied suicidal or homicidal thoughts. The patient asked if the officers could provide transportation to the KACH ER because he had walked to the KD. The officers told the patient they were not authorized to leave VA property. The patient reported to officers the intent to walk to the KACH ER. It was noted in the UOR that it was raining at the time of the officers' interaction with the patient. The patient left the VA property, and one of the officers followed up with a call to the KACH to confirm that the patient had arrived. The KACH employee stated that the patient was there and that they "were trying to get him admitted to the Knoxville VA."

At 9:20 p.m. that same Friday, the AOD received a telephone request from a provider at the KACH ER. The patient's diagnosis included depression and anxiety. The patient was accepted for transfer by the Psychiatric Officer of the Day (POD). Documentation was faxed to KACH, and a voluntary hold was signed by the patient and faxed to the KD's unit 68D (acute mental health inpatient unit). The POD instructed that the patient was to be directly admitted to unit 68D. Ambulance transfer was arranged and paid for by the system. At 10:55 p.m., the patient arrived by ambulance at KD and was admitted

to unit 68D with a diagnosis of paranoid schizophrenia. Three days later, on Monday, the patient was discharged to the KD Domiciliary for continued treatment.

Patient 3

The patient was his early 40s at the time of the event. On a Sunday in the spring of 2008, at 7:57 p.m., the patient's mother called the system's telephone care triage nurse with concerns about the patient's mental health status and a request that the Knoxville Police Department be called to check on the patient. At 7:58 p.m., after an unsuccessful attempt to contact the patient at home, the triage nurse notified the VA Police, who contacted the Knoxville Police Department. At 8:41 p.m., the nurse documented being told by VA Police that the Knoxville Police Department found the patient shaking and not talking, and the patient was taken to the KACH. The KACH provider called the DMD at 11:05 p.m. and the Iowa City VA Medical Center (ICVAMC) at 11:15 p.m. At 11:30 p.m., that same Sunday, the KACH notified a judge that the patient was being committed to the ICVAMC, and necessary documents were sent by facsimile. At 11:40 p.m., the KACH provided a report to the ICVAMC. Early Monday, at 12:20 a.m., a Marion County Sheriff served the commitment papers; and at 12:54 a.m., the patient was transported to the ICVAMC by ambulance with escort. At 2:45 a.m., the patient arrived at the ICVAMC and was admitted to unit 9E (acute mental health inpatient unit) with a diagnosis of chronic undifferentiated schizophrenia. On Tuesday a week later, the patient was discharged to the KD Domiciliary for further management and transition. The ICVAMC arranged for the patient's transportation through the medical center's volunteer transportation network. Four and a half weeks later, the patient was discharged home and continued to receive intensive outpatient mental health treatment at the KD. He was followed by the Day Program and the Mental Health Intensive Case Management program.

Four months after the discharge, on a Saturday in the fall of 2008, at 3:36 p.m., the patient presented at the DMD ER complaining of not feeling well and experiencing hallucinations. The patient also reported not sleeping for 36 hours. The patient was driven to the DMD ER by a friend who reported that the patient had not been taking currently-prescribed medications on a regular basis. The patient reported there were too many medications, they weren't needed, and therefore, he had not been taking them regularly. After the patient was medically cleared, the DMD ER provider contacted the POD and MOD at KD to plan for the patient's admission to unit 68D. At 7:50 p.m., the triage nurse documented that the patient's transfer to KD for admission to unit 68D was arranged. At 8:30 p.m., the patient was transported by ambulance to the KD. At 9:26 p.m. that same Saturday, the patient was admitted to unit 68D with a diagnosis of chronic undifferentiated schizophrenia. On a Thursday after 5 days of hospitalization, the patient was discharged home and continued to receive intensive outpatient mental health treatment at the KD.

Inspection Results

Issue 1: Denial of Care

We did not substantiate that the three patients cited by the complainant were denied care. Each of the patients received necessary initial evaluation at the KACH ER, and in turn, the KACH providers made decisions regarding each patient's care needs. Further care for each of the cited patients was provided by the system.

Transition Planning. Although the effective date of the modified hours for Building 1 at the KD was March 1, 2008, the plan was for the AOD to remain at the KD through April 30, 2008. This provided an opportunity to monitor the effect of the modified hours and to address any issues that arose.

The transition committee addressed a wide variety of issues prior to the implementation of the modified hours at Building 1 at the KD. A decision was made to install a yellow telephone box inside the vestibule of Building 1 to permit patients who arrived after hours to push a red button in order to access VA staff. The call was to be answered either by a VA operator or the AOD at the DMD. A protocol for handling calls from the telephone box was implemented in May 2008.

During interviews with employees, including a number of staff who were members of the transition committee, we asked each to describe what was to occur when a patient pushed the red button. Only a few of these employees provided responses that were consistent with the protocol that had been developed. Based on the responses, it was apparent that many employees lacked a clear understanding of the process, and therefore, did not know their role or the roles of other employees. This included some of the employees who were directly involved in interacting with the three patients whose care we reviewed. Additionally, we learned that there was confusion about the protocol for calling 911, including who would determine the need to call 911, who could place the call, and who would be responsible for the charges. The misunderstanding and confusion about the process and employees' roles and responsibilities impeded the ability of employees to effectively explain the changes to patients.

Emergency Management. At the time of our visit, the procedures and protocols that had been developed related to the modified hours for Building 1 at the KD focused on specific positions, such as the AOD, or services. The system did not have a policy to address the response to and the management of emergencies which occur on VA grounds. Such a policy would provide guidance about the procedures to be followed in emergencies, as well as employees' roles and responsibilities.

Conclusions

We did not substantiate the allegation of denial of after-hours care. We found that the three patients cited by the complainant received further evaluation in a local hospital fully staffed and capable of assessing the immediate needs of the patients. Providers then appropriately collaborated with the system to arrange for further VA care.

Despite the information that was communicated to employees regarding the modified hours for Building 1 at the KD and the new procedures that were being implemented, not every employee fully understood the new procedures, their roles, or the roles of other employees. Because employees were not clear about the process, there was potential for patients to be misinformed regarding what to do if they needed after-hours care.

Additionally, we found that the system did not have a policy to address the response to and the management of emergencies which occur on VA grounds.

Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the System Director assures that all employees who might have to deal with medical emergencies and veterans seeking care after hours at the KD have the necessary information, clear guidance, and instruction.

Recommendation 2. We recommended that the VISN Director require that the System Director establishes a policy to address the response to and management of emergencies which occur on VA grounds.

Comments

The VISN and System Directors agreed with the findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 9–11 for the full text of their comments.) We will follow up on the planned actions until they are completed.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 18, 2009

From: Director, VA Midwest Health Care Network (10N23)

Subject: **Healthcare Inspection – Alleged Denial of After-Hours Care at the VA Central Iowa Health Care System's Knoxville Division, Knoxville, Iowa**

To: Director, Chicago and Kansas City Offices of Healthcare Inspections (54CH/KC)

I have reviewed and concur with the recommendations and responses from VA Central Iowa Health Care System.

Robert A. Petzel

ROBERT A. PETZEL, M.D.

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 18, 2009

From: Director, VA Central Iowa Health Care System (636A6/00)

Subject: **Healthcare Inspection – Alleged Denial of After-Hours Care at the VA Central Iowa Health Care System's Knoxville Division, Knoxville, Iowa**

To: Director, VA Midwest Health Care Network (10N23)

I have reviewed the findings outlined in the VA Office of Inspector General's report dated April 23, 2009, regarding alleged denial of after-hours care at the VA Central Iowa Health Care System's (VACIHCS) Knoxville Division, Knoxville, Iowa (Project No. 2009-00524-HI-0043). VACIHCS concurs with the report findings and conclusions.

Attached you will find our action plans to address the report recommendations.

DC Cooper

DONALD C. COOPER

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

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

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the System Director assures that all employees who might have to deal with medical emergencies and veterans seeking care after hours at the KD have the necessary information, clear guidance, and instruction.

Concur **Target Date of Completion: July 1, 2009**

We will provide additional training and a quick reference guide to staff who deal with medical emergencies to ensure they have the information and guidance needed and that they understand the procedures to be followed when a veteran is seeking care after hours at the Knoxville Division. This will be accomplished no later than July 1, 2009.

Recommendation 2. We recommended that the VISN Director require that the System Director establishes a policy to address the response to and management of emergencies which occur on VA grounds.

Concur **Actions Have Been Completed**

A copy of our policy "Emergency Response on VA Grounds" is attached. (Policy provided as an embedded attachment on original response).

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Verena Briley-Hudson, MN, RN Director, Chicago and Kansas City Offices of Healthcare Inspections (708) 202-2672
Acknowledgments	Paula Chapman, CTRS Roberta Thompson, MSW

Appendix D

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