Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Quality of Care Issues
Amarillo VA Health Care System
Amarillo, Texas

Report No. 09-02797-45

December 9, 2009

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations

Telephone: 1-800-488-8244 between 8:30AM and 4PM Eastern Time, Monday through Friday, excluding Federal holidays

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Executive Summary

The purpose of the review was to determine the validity of allegations regarding air ambulance reimbursement and quality of care issues for a patient treated at the Amarillo VA Health Care System (system) in Amarillo, Texas. A patient and his wife alleged that during a January 2009 admission, the VA authorized an air ambulance to the emergency department (ED) and now refuses to pay the bill, the ED and inpatient admission wait was excessive, the patient waited for 24 hours to see a physician and his diabetes was not treated during that time, the patient's post traumatic stress disorder (PTSD) diagnosis was not considered in assigning a roommate, an anti-anxiety injection left him incoherent for 3 days, and the system's ED and 3 South Inpatient Unit (3S) were unsanitary.

We did not substantiate any of the allegations. The patient was transferred from a private clinic via air ambulance in mid-January. Because his medical condition was not emergent or service connected, the VA is not obligated to pay the patient's co-pay for the air ambulance. The patient was treated in the ED within 20 minutes and was admitted to the medical unit within 4 hours. The patient's PTSD and diabetes were treated appropriately. The patient was given an anti-anxiety injection; however, documentation noted that he was monitored frequently and was easily arousable. We conducted an unannounced environment of care inspection of the ED and 3S and found them to be clean, safe, and free of biomedical waste. Interviews with nursing staff indicated that housekeeping personnel were responsive to cleaning requests.

Because we did not substantiate any of the allegations, we made no recommendations.

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

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

SUBJECT: Healthcare Inspection – Alleged Quality of Care Issues, Amarillo VA Health Care System, Amarillo, Texas

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding the quality of care provided to a patient at the Amarillo VA Health Care System (system) in Amarillo, TX. The allegations included transport billing errors, a long emergency department (ED) and inpatient admission wait, lack of treatment for diabetes, disregard for post traumatic stress disorder (PTSD), over-sedation from anti-anxiety medication, and unsanitary conditions in the system.

Background

The system is a tertiary care facility that provides health care services to approximately 79,000 veterans in 52 counties located in Texas, Oklahoma, eastern New Mexico, and southwest Kansas. The system has 69 hospital beds and 120 community living center beds and is affiliated with Texas Tech University Health Sciences Center, with 56 medical resident positions in Internal Medicine, Family Practice, and Specialty Care training programs. The system is part of Veterans Integrated Service Network (VISN) 18.

During a January 2009 visit to the system, the patient and his wife alleged:

- VA authorized an air evacuation to the ED and now refuses to pay.
- The wait in the ED was excessive.
- The patient did not see a physician for 24 hours and his diabetes was not addressed or treated during that time.
- The patient's PTSD was not considered in assigning a roommate with serious wounds that caused the complainant to experience "flashbacks."
- An injection to reduce the patient's anxiety left him incoherent for 3 days.
- The system's ED and medical unit were unsanitary.

Scope and Methodology

We interviewed the complainants by telephone on July 15, 2009. We conducted a site visit August 10–11, and reviewed the patient's VA and air evacuation records, relevant system policies and procedures, and patient advocate data. We interviewed physicians, nurses, a dietician, a benefits advisor, and a patient advocate who were knowledgeable about the patient's care. We also conducted an unannounced environment of care inspection of the ED and the 3 South Inpatient Unit (3S).

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

Case Summary

In mid-January 2009, a private, non-VA clinician examined the patient for shortness of breath possibly caused by a pulmonary embolism. This clinician ordered an air evacuation to the system's ED and the patient arrived at 7:26 p.m. that evening. Chest x-rays, computer aided tomography (CAT) scan and angiography were taken at the ED but did not indicate acute pulmonary disease. Blood tests, including glucose, liver function, CBC, and C-reactive protein, showed elevated C-reactive protein levels and slightly elevated pH with a low pCO_2.[1] Blood glucose levels were normal, and blood cultures were negative.

The patient was treated in the ED and admitted to 3S 5 hours later, at 12:23 a.m., with a diagnosis of obstructive chronic bronchitis and a recent hospitalization for pneumonia. Additional nursing notes addressed chronic obstructive pulmonary disease (COPD), right sided pleurisy, PTSD, and decubitus ulcers. The patient was taking cardiac and diuretic medications. The patient denied that he was diabetic to both the nurse and resident physician (resident).

The patient was admitted to a semi-private room. Shortly after admission, the patient became agitated over the condition of another patient in the room. He was given a sedative and moved to a private room. A resident physician evaluated the patient at 1:58 a.m. and wrote a treatment plan for the anxiety and related PTSD but noted that the COPD and pneumonia were stable.

At 5 a.m. the patient had elevated blood glucose levels of 258 mg/dL.[2] During rounds at 10 a.m., the dietician was alerted by the wife that the patient had diabetes. The patient had received IV fluids with glucose and a dose of steroids in the ED. No treatment for the elevated glucose had been ordered at that time because the resident and attending physician were trying to definitively determine whether the patient had diabetes.

[1] High pH and low CO_2 suggests hyperventilation (panting).
[2] Normal range 74–118 mg/dL (dL indicates 1/10 percent of a liter).

A mental health evaluation was performed at 10:48 a.m. to rule out anxiety as a cause for the patient's shortness of breath. The psychiatrist concluded that the patient was oriented, alert, cooperative, and mildly depressed but without suicidal thoughts or plans. The patient was offered further mental health treatment at the system, which he declined.

The attending physician examined the patient at 2:46 p.m. and noted that he was admitted with acute respiratory difficulties, underlying PTSD, diabetes, obesity, and obstructive chronic bronchitis. The analysis and treatment plan focused on the patient's hyperventilation, PTSD, and chronic bronchitis.

A system pharmacist retrieved the patient's active medication profile from another VA health care facility where diabetic medications had been dispensed. The resident obtained a definitive history of diabetes mellitus from the patient and initiated a sliding scale insulin dosage to treat diabetes at 4:10 p.m.

On hospital day 2, at 2:30 p.m., the patient was discharged in stable condition. He was given steroids for bronchitis, anti-anxiety medication, and antibiotics for the history of pneumonia.

Inspection Results

Issue 1: Transport Billing

We did not substantiate that the VA was obligated to pay for air ambulance costs not covered by Medicare.

The original order for air evacuation was made by a private clinician in Beaver, OK. The transport was for a CT scan to rule out a pulmonary embolism. The VA Handbook 1601B.05, *Beneficiary Travel*, issued July 29, 2008, outlines eligibility criteria. The patient met the criteria for disability over 30 percent. However, the patient's presenting complaint of shortness of breath/mild respiratory distress with right sided pleurisy was not service related and was not clinically emergent as determined by a VHA clinician.

Issue 2: ED Wait Time

We did not substantiate that the admission process was excessively long.

The patient arrived at the system ED at 7:26 p.m. He was referred by a private clinician for a CT scan to rule out pulmonary embolism. The initial ED physician's exam was performed at 7:40 p.m. and the first treatment for his breathing difficulty was administered by 8:00 p.m. During the next 4 hours, the patient had a complete diagnostic workup for his shortness of breath. Results were received and interpreted for x-rays, CT scans, blood O_2 and CO_2 saturation, chemistry profiles, and blood cell counts. The patient was admitted to 3S at 12:23 a.m.

Issue 3: Diabetic Care

We did not substantiate that the patient received inadequate and untimely care for diabetes.

He received appropriate treatment for diabetes after he admitted having diabetes and when his glucose level indicated he required treatment. In addition, the patient was examined multiple times by the resident under attending physician supervision.

The ED physician's initial assessment refers to a previous history of diabetes. The blood glucose level shortly after arrival in the ED was 111 mg/dL. With this result, the patient was not treated for diabetes in the ED. The patient also denied being diabetic to the 3S admitting nurse and resident physician.

The patient's glucose level was elevated (258 mg/dL) on hospital day 1 at 5 a.m. The resident physician told us he considered the steroid administered in the ED and the glucose in the IV fluids the patient received as contributing to a spike in blood sugar. At 10:30 a.m., the dietician received a complaint from the wife about the patient being served a non-diabetic breakfast. At 4:10 p.m., the patient told the resident physician that he was diabetic. The resident physician ordered sliding scale insulin treatment. The system pharmacist retrieved and reconciled a full pharmacy profile with the patient at 4:58 p.m. confirming that the elevated glucose was not solely caused by medication administered in the system.

Additionally, the wife and patient complained that they did not see a physician for 24 hours; however, the resident physician's notes record visits at 1:58 a.m., 7:00 a.m., 2:00 p.m., 2:48 p.m., and 4:10 p.m. The attending physician visited the patient at 2:46 p.m.

Issue 4: PTSD/ Room Assignment

We did not substantiate that the patient's PTSD was ignored in assigning him to 3S.

The patient's PTSD was addressed in the ED, but he did not require medication or cause exceptional concern because he was calm. Initially, the patient was placed in a semi-private room, but when he became agitated by another patient's condition, he was moved to a private room and a sedative ordered at 1:29 a.m.

Issue 5: Anti-Anxiety Medication

We did not substantiate that the patient was given a sedative which left him incoherent for 3 days.

At 1:30 a.m. on hospital day 1, the patient was given sedation for severe agitation. The patient was checked frequently during the night and there were no nursing notes that

suggested he was overly sedated or unintelligible. From documentation and staff interviews, we concluded the patient was lucid, arousable by calling his name, and independently mobile during this episode of care.

Issue 6: Environment of Care

We did not substantiate unsanitary conditions in either the ED or on 3S.

We did an unannounced onsite environment of care inspection of both the ED and 3S. We inspected patient rooms, work spaces, and common areas. All areas were found to be clean, safe, and free of biomedical hazards. We interviewed employees who work in the ED and 3S as to the cleanliness of occupied and unoccupied rooms. They told us that housekeeping personnel were immediately responsive to cleaning requests.

Conclusions

We did not substantiate the allegations of poor quality care, delay in services, or non-payment of the air ambulance co-pay. We made no recommendations. The VISN and system Directors concurred with our findings.

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

Appendix A

OIG Contact and Staff Acknowledgments

OIG Contact	Virginia L. Solana Director, Denver Office of Healthcare Inspections (303)270-6500
Acknowledgments	Barry L. Simon Laura Dulcie

Appendix B

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