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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Availability of On-Call Interventional Radiology Services and a Related Patient Transfer at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana

Healthcare Inspection | **25-01515-67** | **March 5, 2026**

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Executive Summary

The VA Office of Inspector General (OIG) initiated a healthcare inspection at the Richard L. Roudebush VA Medical Center (facility) in Indianapolis, Indiana, to assess allegations and concerns related to the availability of on-call interventional radiology services, and the timing of a submission of a waiver request to temporarily exempt the facility from the requirement to provide 24/7 interventional radiology coverage.[1] The OIG initiated the inspection in March 2025, completed a site visit from April 28 through May 1, 2025, and conducted additional interviews virtually through September 3, 2025.

In May 2024, VA issued VA Handbook 5007/64, *Pay Administration*, which clarifies that fee basis provider duties must be related to direct patient care activities, thereby preventing VA from paying providers for the time spent being readily available to provide patient care services.[2] In response, facility on-call coverage by fee basis physicians for interventional radiology services ended in October 2024, thus resulting in a reduction in availability of on-call provider coverage at the facility.

Facility On-Call Interventional Radiology Services

According to Veterans Health Administration (VHA) Directive 1220(1), *Facility Procedure Complexity Designation Requirements to Perform Invasive Procedures in Any Clinical Setting,* VHA requires vascular and nonvascular on-call interventional radiology services at the facility to be available on-call within 60 minutes.[3] VHA Directive 1023, *Waivers to VHA National Policy*, states when an infrastructure change is identified that prevents compliance with VHA policy, facilities are required to submit a waiver request.[4] Prior to October 2024, five physicians on fee

[1] For the purposes of this report, on-call coverage refers to a physician being on standby and readily available to respond to medical emergencies or provide urgent medical care outside of regular business hours. Interventional radiology is a specialty within the radiology field of medicine that uses minimally invasive image-guided procedures "to diagnose and treat diseases in nearly every organ system." "What is Vascular and Interventional Radiology," Johns Hopkins Medicine, accessed April 1, 2025, https://www.hopkinsmedicine.org/interventional-radiology/what-is-ir; VHA Directive 1023, *Waivers to VHA National Policy*, March 5, 2024. The directive states that, "a waiver is a written statement that exempts a VHA operating unit from compliance with all or part of a VHA national policy for a specified time period"; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "For Action: Annual Certification of Infrastructure Requirements for Sites Performing Invasive Procedures," memorandum to [all Veterans Integrated Service Network Directors], November 20, 2024.

[2] The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together; VA Handbook 5007/64, *Pay Administration,* May 14, 2024.

[3] VHA Directive 1220(1), *Facility Procedure Complexity Designation Requirements to Perform Invasive Procedures in Any Clinical Setting*, May 13, 2019, amended February 11, 2020.

[4] VHA Directive 1023, *Waivers to VHA National Policy*, March 5, 2024.

basis appointments were compensated on a time basis (for each week of on-call coverage) with additional compensation for performing diagnostic or interventional radiology procedures.[5]

On October 25, 2024, fee basis agreements with the physicians were canceled and patients who had urgent interventional radiology needs were to be diverted or transferred to non-VA facilities.[6] After the agreements were canceled, a facility health system specialist submitted a waiver request in accordance with policy and the waiver was approved.

Patient Transfer

The facility resumed providing on-call services on an intermittent basis in November 2024, using facility interventional radiologists. Although the new availability of the intermittent facility services was communicated to staff and leaders, the intensive care unit (ICU) director and ICU attending physician were not initially included in the communication.

In late 2024, staff confusion regarding the coverage led to a patient with a gastrointestinal bleed being transferred to a non-VA hospital, despite facility interventional radiology coverage being available.

In addition, the OIG learned that an on-call gastroenterology fellow was consulted about the patient's care but did not document an assessment in the electronic health record (EHR) as required.

Facility Response to the Patient's Transfer

The OIG determined that a disclosure was not conducted as required by VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*.[7] The ICU attending physician, chief of quality, and Chief of Staff told the OIG of reasons that disclosure was not warranted that included the belief that the time taken to access interventional radiology services at the facility versus the community would have been similar. However, the patient arrived at the community hospital approximately 2.5 hours after the facility confirmed the site of the gastrointestinal bleed, whereas VHA policy requires on-call interventional radiology services to be available on-call within 60 minutes.[8]

[5] The OIG learned that memoranda were used to establish fee basis appointments with providers and outlined the compensation each provider would receive.

[6] VA Handbook 5005/156, *Staffing*, January 13, 2023. VA strategic business partners are human resources specialists that "perform a full range of HR [human resources] assignments that include … implementing HR policy." Human resources specialists "provide managers with the tools needed to oversee their workforce" including guidance related to staffing and pay.

[7] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[8] VHA Directive 1220(1).

The OIG determined that a related patient safety report was also not processed in accordance with VHA guidance. The VHA National Center for Patient Safety, *JPSR Guidebook,* states that adverse events and close call events that are related to care management or system failures should be investigated as part of the Joint Patient Safety Reporting (JPSR) process.[9] After the patient's unnecessary transfer, a staff member entered a patient safety report into the JPSR system, and a patient safety manager rejected the report for investigation. A patient safety manager and the chief of quality told the OIG that the patient safety report was rejected because the event was related to a clinical decision.[10] However, according to VHA, inadequate clinical decisions are not referenced as a reason to exclude patient safety events.[11] In addition, the OIG determined that the unnecessary transfer was a system failure related to deficient communication and a care management issue, which should have been included in the JPSR process to determine if additional actions were warranted.

A Deputy Chief of Staff conducted an administrative review of the patient's transfer; however, the review was not comprehensive as ICU nurses were not interviewed to understand their involvement.

The OIG made six recommendations to the Facility Director related to communicating changes that affect clinical services to patients, documenting complete and pertinent information in EHRs, completing disclosures of adverse events, following JPSR processes, and conducting a comprehensive review of the patient's care and transfer.

The OIG is aware of VA's transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with the recommendation(s) and provided an acceptable action plan (see appendixes A and B). Based on information provided, the OIG considers recommendation 1 closed. For the remaining open recommendations, the Facility Director shared plans to train attendings, fellows, and residents regarding the requirement to document complete and pertinent information, review the care to determine if institutional disclosure is warranted, and take action if needed; educate providers on VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*; as well as provide JPSR

[9] VHA National Center for Patient Safety, *JPSR Guidebook*, December 2023.

[10] "A Peer Review for Quality Management is a critical review of care performed by a peer." VHA Directive 1190(1), *Peer Review for Quality Management*, November 21, 2018, amended July 19, 2024. A peer review was conducted but did not address delayed care related to the unnecessary transfer.

[11] VHA National Center for Patient Safety, *JPSR Guidebook.*

training and conduct monthly reviews of rejected JPSRs. The OIG will follow up on the planned actions until they are completed.

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Contents

Abbreviations

COS	Chief of Staff
CT	computed tomography
DCOS	Deputy Chief of Staff
EHR	electronic health record
ICU	intensive care unit
JPSR	Joint Patient Safety Reporting
OIG	Office of Inspector General
VAMC	VA Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) initiated a healthcare inspection in March 2025, completed a site visit from April 28 through May 1, 2025, and conducted additional interviews virtually through September 3, 2025, at the Richard L. Roudebush VA Medical Center (facility) in Indianapolis, Indiana, to assess allegations and concerns related to the availability of on-call interventional radiology services.[1]

Background

The facility, part of Veterans Integrated Service Network (VISN) 10, includes the medical center and 11 community-based clinics. The Veterans Health Administration (VHA) classifies the facility as level 1a, high complexity.[2] The facility has 159 hospital beds and 50 domiciliary beds. From October 1, 2023, through September 30, 2024, the facility served 64,669 patients and conducted 4,753 interventional radiology procedures.[3]

Interventional Radiology

Interventional radiology is a specialty within the radiology field of medicine that uses minimally invasive image-guided procedures "to diagnose and treat diseases in nearly every organ system."[4] Imaging, such as fluoroscopy, ultrasound, and computed tomography, is used in interventional radiology to navigate an instrument to a targeted area within the body, which

[1] For the purposes of this report, on-call coverage refers to a physician being on standby and readily available to respond to medical emergencies or provide urgent medical care outside of regular business hours.

[2] VHA Office of Productivity, Efficiency, and Staffing (OPES), "Data Definitions VHA Facility Complexity Model," October 1, 2023. The VHA Facility Complexity Model classifies medical facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex.

[3] The number of interventional radiology procedures includes inpatient and outpatient procedures, as well as 15 on-call cases. The most common after-hours interventional radiology procedures during this period were for gastrointestinal bleeding. The data did not include cardiac catheterization laboratory cases, which are performed by the cardiology service, or interventional neuroradiology procedures, which are not performed at the facility.

[4] The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together; "What is Vascular and Interventional Radiology," Johns Hopkins Medicine, accessed April 1, 2025, https://www.hopkinsmedicine.org/interventional-radiology/what-is-ir.

reduces risk, pain, and recovery time compared to traditional surgery.[5] Interventional radiology procedures consist of vascular and nonvascular techniques.[6]

Invasive Procedure Complexity

The VHA invasive procedure complexity model ensures that facilities have the infrastructure to support the complexity of invasive procedures performed "under the safest possible conditions."[7] Within the model, VHA assigns each facility an invasive procedure complexity designation based on the facility's infrastructure. Scheduled procedures cannot exceed the infrastructure capabilities of the facility.[8] The facility's invasive procedure complexity designation level is inpatient complex, which requires vascular and nonvascular interventional radiology services to be available.[9]

Prior OIG Reports

In 2023, the OIG published a report that identified deficiencies in emergent and outpatient care of a patient with alcohol use disorder. The OIG made seven recommendations, including recommendations for the Facility Director to conduct a comprehensive review of the patient's care and to determine the need to perform an institutional disclosure. All seven recommendations have been closed.[10]

Allegations and Related Concerns

In December 2024 and January 2025, the OIG received complaints related to a reduction in availability of on-call interventional radiology services at the facility. One complainant alleged that the facility should have submitted a waiver request to ensure compliance with VHA policy

[5] "What is Vascular and Interventional Radiology," Johns Hopkins Medicine.

[6] VHA Directive 1220(1), *Facility Procedure Complexity Designation Requirements to Perform Invasive Procedures in Any Clinical Setting*, May 13, 2019, amended February 11, 2020. In this report, interventional radiology includes vascular and nonvascular procedures and does not include cardiac catheterization or neurointerventional procedures. Vascular procedures include interventions through or to the circulatory system, including arteries and veins, outside of the heart and brain. Nonvascular procedures include interventions to all tissues and organs of the body outside of the circulatory system, other than the brain.

[7] "VHA Invasive Procedure Complexity for Surgical Programs," VHA, accessed April 3, 2025, https://www.va.gov/health/surgery/#more_info. For the purpose of this report, invasive procedures are those that "require signature informed consent and involve a skin incision or puncture, or endoscopy, and includes but is not limited to: … vascular diagnostic or interventional procedures …"; VHA Directive 1220(1).

[8] VHA Directive 1220(1).

[9] "VHA Invasive Procedure Complexity for Surgical Programs," VHA; VHA Directive 1220(1).

[10] VA OIG, *Deficiencies in Emergent and Outpatient Care of a Patient with Alcohol Use Disorder at the Richard L. Roudebush VA Medical Center in Indianapolis,* IN, Report No. 21-03680-80, March 29, 2023.

prior to the reduction in coverage.[11] Another complainant alleged that confusion and lack of communication led to a patient being transferred to a community hospital for interventional radiology services, even though on-call interventional radiology services were available at the facility. In March 2025, the OIG opened a hotline inspection to assess the allegations. During the inspection, the OIG also identified and assessed concerns related to a lack of consultation between an intensive care unit (ICU) fellow and an attending physician, deficient documentation in the patient's electronic health record (EHR) by a gastroenterology fellow, and the facility's response to the patient's transfer.

Scope and Methodology

The OIG completed a site visit from April 28 through May 1, 2025. Virtual interviews were conducted prior to and after the site visit.

The OIG interviewed 38 individuals, including the Executive Director of the VHA National Radiology Program; VISN staff; and facility senior leaders, service chiefs and supervisory staff, quality management staff, frontline clinical staff, and an administrative staff member.[12]

The OIG reviewed VHA and facility policies; standard operating procedures; external standards and literature; the patient's EHR, including community hospital records that were in the EHR; quality management reviews; and facility communications. In addition, the OIG reviewed facility data related to the number of interventional radiology procedures performed but did not independently verify the data for accuracy or completeness.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews

[11] A waiver is required when an infrastructure change prevents compliance with VHA policy. VHA Directive 1023, *Waivers to VHA National Policy,* March 5, 2024; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "For Action: Annual Certification of Infrastructure Requirements for Sites Performing Invasive Procedures," memorandum to [all VISN Directors], November 20, 2024.

[12] VISN staff included the deputy chief medical officer, senior strategic business partner, and acting senior strategic business partner. Senior leaders included the Facility Director, Chief of Staff, and the Associate Director of Patient Care Services.

available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Patient Case Summary

The patient was in their late 70s and was admitted to the facility in late 2024 with sepsis from a chronic unhealed foot wound.[13] On hospital day 2, the patient underwent an urgent below the knee guillotine amputation to control the infection and was admitted to the step-down unit. The patient's postoperative recovery was challenged by a myocardial infarction and mental status changes.

On hospital day 11, the patient reported abdominal pain, and at 4:00 p.m. was noted to be hypotensive, experienced a drop in hemoglobin level, and passed maroon-colored stool, consistent with bleeding from the gastrointestinal tract. A step-down unit resident physician ordered intravenous fluid and documented that "GI [gastroenterology service] was consulted and wanted CTA [computed tomography (CT) angiogram] abd/pelvis [*sic*] and to be updated after fluid resuscitation. They [gastroenterology service] are not doing a procedure [endoscopy on the patient] imminently but are aware and following overnight." At 6:15 p.m., an on-call resident asked the nurse to hold transporting the patient to radiology for the CT angiogram, as the patient was hemodynamically unstable. A blood transfusion was started, and the patient was transferred to the ICU at approximately 7:00 p.m. with the admitting diagnosis of hemorrhagic shock due to gastrointestinal bleeding. The ICU staff then administered multiple additional blood transfusions and started the patient on a vasopressor infusion to stabilize the blood pressure.[14] The patient was transported to undergo the CT angiogram at 8:35 p.m. At 9:06 p.m., an ICU resident physician documented in the patient's EHR having consulted gastroenterology.

At 10:34 p.m., a radiologist communicated to an ICU fellow that the CT angiogram showed an actively bleeding duodenal ulcer. The ICU resident documented that the gastroenterology consultant had assessed the patient, and at 11:26 p.m., the ICU resident entered an order to transfer the patient to a community hospital for urgent embolization. The patient was transported by ambulance to the accepting community hospital's ICU and arrived at 1:00 a.m., approximately 2.5 hours after the reported results of the CT angiogram.

[13] The OIG uses the singular form of they, "their" in this instance, for privacy purposes.

[14] In addition to the transfusion of one unit of packed red blood cells (PRBCs) administered prior to transfer to the ICU, the patient received three more units of PRBCs and one unit of platelets on the evening of admission to the ICU, prior to transfer to the community hospital hours later.

Soon after arrival at the accepting facility, the patient became acutely unstable, requiring intubation, advanced cardiac life support, and blood transfusions. The patient subsequently underwent urgent interventional radiology embolization of the suspected source of gastrointestinal bleeding, however, died several days later.

Inspection Results

1. Facility On-Call Interventional Radiology Services

The OIG did not substantiate that a waiver request should have been submitted prior to reducing availability of facility on-call interventional radiology services. The OIG found facility leaders submitted a waiver request in accordance with VA policy after on-call coverage by fee basis providers ended.

Cancellation of Fee Basis Memoranda

According to VHA Directive 1220(1), *Facility Procedure Complexity Designation Requirements to Perform Invasive Procedures in Any Clinical Setting, a* procedural complexity level of *inpatient complex* requires vascular and nonvascular interventional radiology services to be on-site during day shift hours, and on-call with a response time of no more than 60 minutes during all other hours.[15]

VHA Handbook 5007, *Pay Administration*, states that fee basis physicians "are to be compensated by the task or service (i.e., by piecework) and are not to be paid on a time basis."[16] In May 2024, VA issued a policy clarification that fee basis provider duties must be related to direct patient care activities.[17]

During an OIG interview, the chief of radiology stated that prior to VA's policy clarification, the facility's two interventional radiologists "covered all weekdays during normal working hours as well as 20 weeks of afterhours on-call duties each year," and five fee basis physicians covered the remaining 32 weeks of on-call duties. The OIG reviewed the fee basis memoranda (employee agreements) that were in place prior to the policy clarification and found that the five physicians on fee basis appointments were compensated on a time basis (for each week of on-call coverage) with additional compensation for performing diagnostic or interventional radiology procedures.[18]

[15] VHA Directive 1220(1).

[16] VA Handbook 5007, "Setting Rates of Pay Upon Appointment," updated June 13, 2005, and September 30, 2011, Part II Appendix F in *Pay Administration*.

[17] VA Handbook 5007/64, *Pay Administration,* May 14, 2024.

[18] The OIG learned that memoranda were used to establish fee basis appointments with providers and outlined the compensation each provider would receive.

The chief of radiology reported learning of the policy clarification from a human resources staff member in August 2024, and subsequently working on solutions, such as developing new fee basis memoranda to align with VHA policy and exploring contracting with providers.[19] However, the chief of radiology stated the fee basis physicians did not agree to the new memoranda since compensation for being on standby and readily available was not included, and fiscal service would not provide funding for contracting with providers.

On October 10, 2024, the senior strategic business partner expressed concern to the Chief of Staff (COS) and Facility Director regarding the discrepancy between the existing fee basis memoranda and VHA policy.[20] The senior strategic business partner told the OIG that "paying the fee basis [providers for being on-call] was not appropriate/legal according to our policies." On October 25, 2024, the senior strategic business partner canceled the fee basis memoranda with the Facility Director's concurrence, resulting in fee basis physicians no longer providing on-call coverage. Since there were no alternative coverage options in place, the facility's contingency plan was to divert or transfer all patients with urgent interventional radiology needs to non-VA facilities when the facility's two interventional radiologists were not on duty.

Waiver Request Submitted and Approved

A procedural complexity designation is meant to ensure that invasive procedures performed at the facility do not exceed the infrastructure requirements.[21] According to VHA Directive 1023, *Waivers to VHA National Policy,* facilities are required to submit a waiver request when an infrastructure change is identified that prevents compliance with VHA policy.[22] The OIG learned that complexity waiver requests are generated at the facility level, routed through the VISN, and the Invasive Procedure Complexity Waiver Clinical Council reviews the waiver request and makes a final determination.

[19] In an email, the radiology business manager reported that fee basis memoranda are agreements with individuals as opposed to contracts, which are agreements that are typically made with a company. Further, contracts are "more extensive" than fee basis memoranda "in their obligations, quality standards and performance metrics." The radiology business manager told the OIG that contracting would allow providers to be compensated for time on-call as opposed to strictly by task.

[20] VA Handbook 5005/156, *Staffing*, January 13, 2023. VA strategic business partners are human resources specialists that "perform a full range of HR [human resources] assignments that include … implementing HR policy." Human resources specialists "provide managers with the tools needed to oversee their workforce" including guidance related to staffing and pay.

[21] VHA Directive 1220(1).

[22] VHA Directive 1023, *Waivers to VHA National Policy*, March 5, 2024. The directive states that, "a waiver is a written statement that exempts a VHA operating unit from compliance with all or part of a VHA national policy for a specified time period"; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "For Action: Annual Certification of Infrastructure Requirements for Sites Performing Invasive Procedures," memorandum.

The COS reported notifying a VISN leader of the reduction in the availability of interventional radiology services on the day the fee basis memoranda were canceled. That same day, the chief of radiology submitted an issue brief. On December 12, 2024, a facility health system specialist submitted a waiver request to VISN staff.[23]

The OIG reviewed VHA policy and found there was not a time requirement for when a waiver request must be submitted related to an infrastructure change.[24] The Executive Director of the VHA National Radiology Program, VISN Deputy Chief Medical Officer, and facility COS reported to the OIG the opinion that the facility submitted the waiver request timely. The Executive Director of the VHA National Radiology Program also explained that submitting waiver requests after a reduction in service is acceptable as changes may occur unexpectedly.

On June 5, 2025, the Invasive Procedure Complexity Waiver Clinical Council approved the waiver for a period of six months, with the stipulation that the facility seeks on-call coverage as required to meet the designated complexity level.[25] At the time of this inspection, the COS told the OIG that the facility had identified three providers for potential direct hire to provide additional on-call coverage.

The OIG concluded that facility leaders submitted a waiver request after the reduction in availability of facility on-call interventional radiology services in accordance with VHA policy.

2. Patient Transfer

The OIG substantiated that confusion and deficient communication contributed to the ICU fellow's decision to transfer the patient to a community hospital for an interventional radiology procedure, despite on-call services being available at the facility. As a result, the patient experienced a delay in being evaluated for a procedure that may have stopped the gastrointestinal bleeding. Additionally, the ICU fellow did not consult with the attending physician as required when making the decision to transfer the patient, and the consulted gastroenterology fellow did not document a patient assessment, despite participating in the patient's care.

[23] The chief of radiology reported drafting the waiver request on November 13, 2024. On November 22, 2024, the health system specialist requested guidance from the VISN to route the waiver request. On December 12, 2024, the VISN responded with the guidance for routing.

[24] VHA Directive 1023.

[25] The OIG learned through documentation and email correspondence that the VISN Director approved the waiver request on December 17, 2024, and submitted the waiver request to the Under Secretary for Health's office on January 3, 2025. On February 12, 2025, the Invasive Procedure Complexity Waiver Clinical Council requested additional information from the facility. The VISN responded with the requested information on March 14, 2025, and the Invasive Procedure Complexity Waiver Clinical Council approved the waiver request on June 5, 2025.

Communication Processes

"Effective communication is a necessity to meet patient needs and to provide high-quality services."[26] In contrast, poor communication may lead to negative outcomes, including discontinuity of care and compromises to patient safety.[27] According to facility policy, *On-Call and Callback Schedules*, call schedules identifying the individuals to be called to the facility are required to be published on an electronic site.[28] The OIG learned during interviews with the COS and clinical staff that facility staff use the call schedule site to identify providers who are on-call.[29]

Intermittent Coverage Notifications

During an OIG interview, the chief of radiology reported contacting the chief of medicine after the fee basis memoranda were canceled to provide notification that on-call interventional radiology services were not available. Additionally, on October 28, 2024, the chief of radiology sent an email to facility senior leaders, service chiefs, and medicine service section chiefs indicating that on-call interventional radiology services would be on diversion "until further notice."

The OIG reviewed email correspondence and found that the facility resumed providing on-call interventional radiology services on an intermittent basis as early as November 2024.[30] The COS and chief of radiology told the OIG that the intermittent services were communicated to staff and leaders through emails and daily calls.[31] However, the OIG found that the ICU director and ICU attending physician were not included on email communication and did not participate in the daily calls between October 28 and the date of the patient's transfer. The OIG learned a radiology supervisor emailed the notification of intermittent on-call coverage to multiple email groups, as opposed to individual recipients, that included a group with a title that referenced ICU

[26] Raluca Alexandra Ifrim et al., "Communication, an important link between healthcare providers: a best practice implementation project," *JBI Evidence Implementation* 20, no. S1 (August 2022): S41-S48, https://doi.org/10.1097/XEB.0000000000000319.

[27] P. Vermeir et al., "Communication in healthcare: a narrative review of the literature and practical recommendations," *The International Journal of Clinical Practice* 69, no. 11 (July 2015): 1257-1267, https://doi.org/10.1111/ijcp.12686.

[28] Facility policy 11-72, *On-Call and Callback Schedules*, January 13, 2022.

[29] Clinical staff included physicians, a fellow, a resident, and nursing staff.

[30] DCOS 2 told the OIG that the facility planned to have the two full-time interventional radiologists cover a total of 20 weeks out of the year.

[31] According to the deputy chief of quality, safety, and value, daily calls are part of a communication strategy to share critical information with "nursing leadership, administrative personnel, clinical support teams, operational staff, and others." The deputy chief of quality, safety, and value stated that daily calls are conducted virtually through an electronic application that includes an option for attendees to enter chat messages, which are visible to the attendees on the call. Information regarding the availability of on-call intermittent interventional radiology coverage was shared through chat messages.

leaders. The radiology supervisor believed that the ICU director was included as a member of that email group, and the information would then be relayed to ICU physicians. However, the OIG reviewed the recipient list and found that the email group did not include the ICU director. Additionally, a Deputy Chief of Staff (DCOS 1) told the OIG that staff and service chiefs were not required to participate in the daily calls but noted that the ICU attending physician and ICU director had a "standing invitation" to attend. However, neither the ICU attending physician nor the ICU director recalled receiving an invitation.

Information Relayed Regarding On-Call Interventional Radiology Staff

The patient was transferred to a community hospital after developing a gastrointestinal bleed that required an urgent interventional radiology procedure.[32] However, the OIG reviewed the call schedule and found the call schedule reflected that facility interventional radiology staff were on-call and would have been able to complete the procedure at the facility. During an OIG interview, the ICU fellow reported not checking the call schedule because radiology staff previously indicated that on-call coverage was not available. Additionally, the ICU fellow reported being told that an ICU nurse "took it upon themselves" to call and confirm if interventional radiology was on-call and was told that coverage was not available; however, the ICU fellow was unable to recall the name of the ICU nurse.

In emails to the OIG, multiple ICU nurses reported checking the call schedule, which indicated that on-call interventional radiology services were available; however, due to confusion and ambiguity regarding the changes in coverage, ICU nurses contacted the nursing officer of the day to confirm that the information displayed in the call schedule was correct.[33] ICU nurses reported that the nursing officer of the day responded that interventional radiology staff were not on-call. During an OIG interview, the nursing officer of the day could not recall being contacted regarding the patient or interventional radiology services. Due to these conflicting recollections, the OIG was unable to determine the source of the misinformation provided to the ICU fellow. The ICU fellow told the OIG that the decision to transfer the patient was based on the impression that there was no on-call interventional radiology available and trusting the ICU nurse.

The ICU director and ICU attending physician told the OIG of believing that better communication of the change to intermittent coverage could have prevented the patient's transfer. Notably, another Deputy Chief of Staff (DCOS 2) told the OIG that residents and fellows would not receive notification of the change to intermittent coverage by email, and

[32] Although the ICU resident entered documentation related to the patient's transfer, the ICU fellow told OIG of initiating the transfer to a community hospital.

[33] The nursing officer of the day assumes authority and responsibility for managing employees and allocating resources after hours when nursing leadership is not available. The Associate Director Patient Care Services told the OIG that staff are expected to contact the nursing officer of the day for assistance with determining who is on-call.

would instead receive the information directly from the supervising attending physician.[34] Since the ICU attending physician was not included in communications of the change to intermittent on-call availability, the information was not relayed to the ICU fellow. During an interview with the OIG, the chief of radiology stated the belief that the intermittent nature of on-call interventional radiology coverage contributed to the uncertainty of its availability. DCOS 2 described the communication of on-call availability leading up to the patient's transfer as "suboptimal."

After the patient transfer, DCOS 1 emailed clarification to leaders and staff, including the ICU director and the ICU attending physician. The clarification specified that intermittent interventional radiology on-call coverage had been available since "approximately November" and reinforced instruction for staff to review the call schedule if a consultation or procedure was needed. The COS, DCOS 2, and chief of radiology told the OIG that no further incidents have occurred regarding the identification of available on-call coverage.

The OIG concluded that confusion and deficient communication, including omitting ICU staff from notifications of resumption of on-call coverage on an intermittent basis, contributed to the patient's unnecessary transfer to a community hospital. The OIG was unable to determine the source of the misinformation provided to the ICU fellow.

Attending Physician Consultation

According to VHA Directive 1400.01, *Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents*, residents and fellows are required to consult with attending physicians to ensure that patient transfers are "appropriate."[35]

The OIG found that the ICU fellow did not consult with the ICU attending physician prior to deciding to transfer the patient. During an OIG interview, the ICU fellow acknowledged that, in retrospect, the ICU attending physician should have been contacted to review the care provided to the patient. The ICU fellow explained that the lack of consultation was due to the belief that the patient was hemodynamically stable, the transfer had been arranged, and no further recommendations could be provided by the ICU attending physician. The ICU attending physician told the OIG of having the expectation of being notified of a transfer and addressing the lack of consultation with the ICU fellow the following day.

Because the ICU attending physician was unaware that interventional radiology services were intermittently available—and that on-call interventional radiology coverage was available on the

[34] DCOS 2 explained that residents and fellows would not receive notification of service changes by email since residents and fellows work at the facility intermittently and would not have a need to regularly access and review facility emails.

[35] VHA Directive 1400.01, *Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents*, November 7, 2019.

day of the patient's transfer—the OIG recognizes that consultation was unlikely to result in the identification that interventional radiology services were available to be provided at the facility. However, consultation would have allowed the ICU attending physician an opportunity to provide input related to the patient's care and transfer.

The OIG concluded that the ICU fellow did not consult with the ICU attending physician as required regarding the patient's transfer to ensure the transfer was appropriate. The OIG did not make a recommendation because the ICU attending physician addressed the expectation with the ICU fellow.

Gastroenterology Documentation

Facility policy, *Completion of Patient Health Records,* requires patient EHRs to contain complete, clinically pertinent, and sufficient information to serve as a basis to plan patient care.[36] Providers should obtain a gastroenterology consultation for an upper gastrointestinal bleed to allow adequate planning and stabilization prior to performing an endoscopy.[37]

Prior to the patient's transfer, step-down unit and ICU staff documented in the patient's EHR that the gastroenterology service was consulted. However, the OIG reviewed the EHR and found no documentation from a gastroenterology provider. During an OIG interview, the on-call gastroenterology fellow reported

- receiving notification from an ICU resident that the patient was hemodynamically unstable, was transferred to the ICU, and had potential active bleeding;
- arriving at the facility's ICU;
- assessing the patient; and
- consulting with the gastroenterology attending physician.

The on-call gastroenterology fellow told the OIG that the patient was unstable, would not tolerate an endoscopy, and the gastroenterology attending physician recommended stabilizing the patient first. However, during an OIG interview, the gastroenterology attending physician could not recall any information regarding the patient and was unable to access the patient's EHR to review historical information.[38] Due to conflicting recollections and the lack of EHR documentation, the OIG is unable to determine what information was communicated to the

[36] MPC HIMS-05, *Completion of Patient Health Records*, March 16, 2020.

[37] Wasif Abidi and John R. Saltzman, "Nonvariceal Upper Gastrointestinal Bleeding," Scientific American Gastroenterology, Hepatology, and Endoscopy, doi:10.2310/7900.5435, accessed October 8, 2025, https://www.deckerip.com/media/SAGHE_tid5435.pdf.

[38] The gastroenterology attending physician was employed by a local university but was credentialed and privileged at the facility to provide oversight of gastroenterology fellows who provide care at the facility. The gastroenterology attending physician reported taking on-call duties approximately three weeks per year and did not have VA EHR access.

gastroenterology attending physician by the on-call gastroenterology fellow to inform medical decision-making and the basis for subsequent verbal guidance provided by the gastroenterology fellow to the ICU team.

The on-call gastroenterology fellow told the OIG that typically, gastroenterology staff who are on-call overnight do not document in a patient's EHR unless a procedure is performed or a recommendation is made. However, the gastroenterology attending physician reported that on-call gastroenterology fellows who arrive at the facility and complete an assessment are expected to conduct a chart review, complete a history and physical examination, discuss the details and plan with the attending physician, and "document everything in detail." When asked by the OIG why the recommendation for stabilization was not documented, the on-call gastroenterology fellow acknowledged that documentation should have been entered but noted it "would not have changed [the] patient status or course."

Notably, the chief of medicine and gastroenterology section chief told the OIG that the gastroenterology fellow was not required to enter documentation in the patient's EHR since other providers documented gastroenterology's "input." However, the OIG found that the referenced documentation was incomplete and did not include the gastroenterology physician's assessment and subsequent recommendations. Additionally, the COS, who provides oversight of the chief of medicine and the gastroenterology section chief, told the OIG that the on-call gastroenterology fellow should have documented the assessment, communication with the ICU resident, the decision-making, and intervention in the patient's EHR.

The OIG concluded that the on-call gastroenterology fellow did not follow facility policy to document complete, clinically pertinent, and sufficient information in the patient's EHR despite participating in the patient's care.

3. Facility Response to the Patient's Transfer

The OIG determined that a clinical or institutional disclosure was not conducted to inform the patient's family or representative about the delay in care.[39] Additionally, the OIG found that quality management staff did not process a related patient safety report in accordance with VHA policy. While DCOS 2 conducted an administrative review of the patient's transfer, the review was not comprehensive and did not identify the source of the misinformation provided to the ICU fellow.

Clinical or Institutional Disclosure

According to VHA Directive 1004.08, *Disclosure of Adverse Events to Patients,* VHA requires the disclosure of "harmful or potentially harmful adverse events to patients or their personal

[39] Care begins with a provider's evaluation of the patient, which may be followed by diagnosis and treatment.

representatives." A clinical disclosure "is a process by which the patient's clinician informs the patient or the patient's personal representative, as part of routine clinical care, that a harmful or potentially harmful adverse event has occurred during the patient's care." An institutional disclosure must be performed for adverse events that have "resulted in or is reasonably expected to result in death or serious injury."[40]

The OIG asked the patient's ICU attending physician, the COS, and the chief of quality, safety, and value (chief of quality) if disclosure was conducted after the patient's transfer and received the following responses:

- The ICU attending physician stated that a clinical disclosure was not conducted because of the belief that the ICU team "followed standard protocol" when transferring the patient.
- The chief of quality stated the belief that care provided to the patient was clinically appropriate, the patient was transferred in stable condition, death was not related to the timing of interventional radiology treatment, and the time taken to access interventional radiology services at the facility versus the community would have been "virtually similar."
- The COS reported discussing the need for an institutional disclosure with the chief of quality and the risk manager and determining an institutional disclosure was not required "given the complexities" of the patient. Additionally, the COS noted that the patient was stable upon transfer.[41]

However, timely intervention to stop a significant gastrointestinal bleed is critical to improving patient outcomes and is a basic principle in medicine.[42] VHA policy requires facility on-call interventional radiology services to be available within 60 minutes.[43] By comparison, the patient arrived at the community hospital approximately 2.5 hours after the facility medical staff confirmed the site of bleeding in the gastrointestinal tract through the CT angiogram results. Soon after arrival to the community hospital, the patient became acutely unstable, requiring life-

[40] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[41] The risk manager told the OIG that a discussion to consider institutional disclosure did not occur. Additionally, the chief of quality could not recall the risk manager being a part of a discussion regarding institutional disclosure. Due to conflicting recollections between the COS, chief of quality, and risk manager, the OIG was unable to determine if the risk manager participated in the discussion.

[42] Jeremy W. Cannon, "Hemorrhagic Shock," *The New England Journal of Medicine* 378 no. 4 (January 24, 2018): 370-379, https://www.nejm.org/doi/full/10.1056/NEJMra1705649#body-ref-r64.

[43] VHA Directive 1220(1).

sustaining treatment that included advanced cardiovascular life support, intubation, and a "massive" blood transfusion.[44]

The OIG concluded that the delay in care caused by the unnecessary transfer warranted a clinical disclosure, and an institutional disclosure should be reconsidered. While the OIG is unable to determine if the delay in care directly contributed to the patient's clinical deterioration and death, transferring the patient delayed access to interventional radiology services.

The Facility's Review of the Patient's Care

In VHA, frontline staff may utilize the Joint Patient Safety Reporting (JPSR) system to report patient safety events.[45] According to the *VHA National Center for Patient Safety, JPSR Guidebook*, after a JPSR report is entered, the facility's patient safety manager determines whether the event should be investigated and analyzed to review the causes to prevent future occurrences.[46] Follow-up actions, such as a comprehensive investigation, are then assigned if warranted.[47] Adverse and close call events that are related to care management or system failures should not be excluded from the JPSR process.[48]

After the patient's transfer, a staff member entered a patient safety report into the JPSR system, and a patient safety manager rejected the report for investigation. A patient safety manager and the chief of quality told the OIG that the patient safety report was rejected because the event was related to a clinical decision.[49] However, according to VHA, inadequate clinical decisions are not referenced as a reason to exclude patient safety events.[50] Further, the OIG determined that the unnecessary transfer was a system failure related to deficient communication and was a care management issue, which should have been included in the JPSR process to determine if additional action was warranted.

The day after the patient's transfer, the chief of radiology notified DCOS 2 that the patient had been transferred, despite on-call interventional radiology services being available. DCOS 2 told the OIG of conducting a review of the event that included reviewing the patient's EHR, and questioning the ICU attending physician, ICU fellow, and chief of radiology. DCOS 2 found that

[44] The patient suffered a pulseless electrical activity arrest, a type of cardiac arrest commonly associated with hemorrhagic shock and resulting in inadequate circulating blood volume to maintain critical bodily functions.

[45] VHA National Center for Patient Safety*, JPSR Guidebook*, December 2023. The JPSR system is an electronic "user-based reporting system" that "captures real time patient safety event (adverse and close call) reporting data from all VHA care sites."

[46] VHA National Center for Patient Safety, *JPSR Guidebook*.

[47] VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs,* March 24, 2023, amended March 5, 2024.

[48] VHA National Center for Patient Safety, *JPSR Guidebook.*

[49] "A Peer Review for Quality Management is a critical review of care performed by a peer." VHA Directive 1190(1), *Peer Review for Quality Management*, November 21, 2018, amended July 19, 2024. A peer review was conducted but did not address delayed care related to the unnecessary transfer.

[50] VHA National Center for Patient Safety, *JPSR Guidebook.*

the ICU fellow relied on misinformation obtained from nursing staff and made the decision to transfer the patient to a community facility for interventional radiology services. However, DCOS 2 reported not discussing the event with the involved ICU nurses and did not follow up with the Associate Director Patient Care Services to understand nursing staff's involvement. Notably, the COS, Associate Director Patient Care Services, and chief of quality reported not knowing the source of the misinformation that was provided to the ICU fellow.

The OIG concluded that the JPSR was erroneously rejected, which may have limited opportunities for additional actions to review the event, such as a comprehensive investigation. Further, the OIG determined that DCOS 2's review was not comprehensive since the review did not include discussion with the ICU nurses. Therefore, a comprehensive review of the patient's care and transfer is warranted to identify factors that contributed to the patient's unnecessary transfer.

Conclusion

In May 2024, VA issued policy clarification regarding fee basis providers that resulted in a reduction of availability of on-call coverage for interventional radiology services. In response, the facility submitted a waiver request in accordance with VA policy and began providing intermittent on-call interventional radiology services.

Confusion and deficient communication related to the restoration of on-call interventional radiology services on an intermittent basis led to a patient being transferred unnecessarily to a community hospital to receive an interventional radiology procedure. The patient's ICU attending physician and the ICU director were not informed of the change to intermittent on-call coverage leading up to the transfer and, therefore, did not relay the change in coverage to the ICU fellow. Additionally, an ICU nurse relayed inaccurate information regarding the unavailability of on-call interventional radiology services at the facility to the ICU fellow, who then transferred the patient. Due to conflicting recollections, the OIG was unable to determine the source of the misinformation provided to the ICU fellow.

During the inspection, the OIG found that the ICU fellow did not consult with the attending physician regarding the patient's transfer to ensure the transfer was appropriate. Additionally, the gastroenterology fellow did not follow facility policy to document complete, clinically pertinent, and sufficient information in the patient's EHR.

The delay in care caused by the unnecessary transfer warranted a clinical disclosure, and an institutional disclosure should be reconsidered. While the OIG is unable to determine if the delay in care directly contributed to the patient's clinical deterioration and death, transferring the patient delayed access to interventional radiology services.

A JPSR was erroneously rejected, which may have limited opportunities for additional actions to review the event, such as a comprehensive investigation. Additionally, DCOS 2's review was not

comprehensive since the review did not include a discussion with the ICU nurses or identify and address the source of the misinformation provided to the ICU fellow. Therefore, a comprehensive review of the patient's care and transfer is warranted to identify factors that contributed to the patient's unnecessary transfer.

The OIG made six recommendations to the Facility Director. The Facility Director concurred with the findings and recommendations (see appendixes A and B). In addition to training attendings, fellows, and residents regarding the requirement to document complete and pertinent information, the Facility Director shared plans to review the care to determine if institutional disclosure is warranted and take action if needed, educate providers on VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, and provide JPSR training and conduct monthly reviews of rejected JPSRs. The Facility Director also planned to do a comprehensive review of the care and take corrective actions to mitigate risks that contributed to the transfer.

The OIG is aware of VA's transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

Recommendations 1–6

1. The Richard L. Roudebush VA Medical Center Director establishes a process to ensure that changes impacting the availability of clinical services to patients are clearly communicated to all relevant staff members.

2. The Richard L. Roudebush VA Medical Center Director ensures that residents, fellows, and clinical service leaders understand and follow the requirement to document complete and pertinent information, including assessments and recommendations, in patients' electronic health records.

3. The Richard L. Roudebush VA Medical Center Director educates providers on the requirements related to completing a clinical disclosure when an adverse event occurs, such as a delay in care.

4. The Richard L. Roudebush VA Medical Center Director ensures the episode of care related to the patient's transfer is reviewed to determine whether an institutional disclosure is needed in accordance with Veterans Health Administration requirements, and takes action as warranted.

5. The Richard L. Roudebush VA Medical Center Director monitors to ensure that Joint Patient Safety Reporting system reports are included or rejected in accordance with Veterans Health Administration guidance.

6. The Richard L. Roudebush VA Medical Center Director ensures a comprehensive review of the patient's care and transfer is completed to identify factors that contributed to the patient's unnecessary transfer and takes action as warranted.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: January 22, 2026

From: Interim Network Director, Veterans Affairs (VA) Healthcare System Serving Ohio, Indiana, and Michigan (10N10)

Subj: VA OIG Report, Review of Availability of On-Call Interventional Radiology Services and a Related Patient Transfer at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana

To: Director, Office of Healthcare Inspections (54HL10)
Chief Integrity and Compliance Officer (10OIC)

1. We appreciate the opportunity to work with the Office of Inspector General as we continuously strive to improve the quality of health care for the Nation's Veterans. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values.

2. I concur with the report findings and recommendations of the OIG report, Review of Availability of On-Call Interventional Radiology Services and a Related Patient Transfer at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana.

3. Should you need further information, contact the Veterans Integrated Services Network Quality Management Officer.

(*Original signed by:*)

Jill Dietrich Mellon, JD, MBA, FACHE

[OIG comment: The OIG received an initial memorandum from VHA on December 31, 2025, and an updated memorandum on January 22, 2026.]

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: January 21, 2026

From: Medical Center Director, Richard L. Roudebush VA Medical Center (583/00)

Subj: Veterans Affairs (VA) OIG Report, Review of Availability of On-Call Interventional Radiology Services and a Related Patient Transfer at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana

To: Director, VA Healthcare System Serving Ohio, Indiana, and Michigan (10N10)

1. I have reviewed the draft report and concur with the action plan as submitted. The Richard L. Roudebush VA Medical Center is committed to honoring our Veterans by ensuring they receive high-quality healthcare services. We deeply regret the circumstances that impacted the quality of care delivered to one of our Veterans. I would like to thank the Office of Inspector General for their thorough review of this case.

2. Should you need further information, please contact the Richard L. Roudebush VA Medical Center Chief of Quality, Safety, and Value.

(*Original signed by*:)

Michael E. Hershman, MHA, FACHE

[OIG comment: The OIG received an initial memorandum from VHA on December 31, 2025, and an updated memorandum on January 22, 2026.]

Facility Director Response

Recommendation 1

The Richard L. Roudebush VA Medical Center Director establishes a process to ensure that changes impacting the availability of clinical services to patients are clearly communicated to all relevant staff members.

_X _Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

The facility has an established process in place for all services, with amion serving as the single authoritative source for on-call schedules. Following the event, a reminder email was sent to all staff to emphasize the use of amion for checking the availability of Interventional Radiology (IR) services. The intensive care unit (ICU) leadership email group was updated on November 18, 2025, to clearly indicate that it is for the ICU nursing leadership team only. Changes in clinical service availability are additionally reinforced through the tiered huddle system to support real-time situational awareness across shifts.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 2

The Richard L. Roudebush VA Medical Center Director ensures that residents, fellows, and clinical service leaders understand and follow the requirement to document complete and pertinent information, including assessments and recommendations, in patients' electronic health records.

_X _Concur

____Nonconcur

Target date for completion: July 2026

Director Comments

Medicine and Gastroenterology services will conduct training for all attendings, fellows, and residents to emphasize the requirement to document complete and pertinent information. This training will include a formal assessment and any recommendations for all bedside consults, regardless of whether a procedure is ultimately performed. To ensure ongoing understanding,

this requirement will be incorporated into annual onboarding and new employee orientation materials for new attendings, fellows, and residents.

Recommendation 3

The Richard L. Roudebush VA Medical Center Director educates providers on the requirements related to completing a clinical disclosure when an adverse event occurs, such as a delay in care.

_X _Concur

____Nonconcur

Target date for completion: July 2026

Director Comments

Risk Management and the Chief of Staff will provide education on the requirements of VHA Directive 1004.08, Disclosure of Adverse Events to Patients, including clinical disclosure expectations for adverse events such as delays in care, during Peer Review Committee and Quality Safety Value Committee meetings.

Recommendation 4

The Richard L. Roudebush VA Medical Center Director ensures the episode of care related to the patient's transfer is reviewed to determine whether an institutional disclosure is needed in accordance with Veterans Health Administration requirements, and takes action as warranted.

_X _Concur

____Nonconcur

Target date for completion: July 2026

Director Comments

The Risk Manager and Chief of Staff are conducting a review of the patient's episode of care to determine whether an institutional disclosure is warranted in accordance with VHA Directive 1004.08, Disclosure of Adverse Events to Patients. Action will be taken as needed based on the outcome of the review.

Recommendation 5

The Richard L. Roudebush VA Medical Center Director monitors to ensure that Joint Patient Safety Reporting system reports are included or rejected in accordance with Veterans Health Administration guidance.

_X _Concur

____Nonconcur

Target date for completion: September 2026

Director Comments

Facility Patient Safety Managers (PSMs) will complete refresher training on the Joint Patient Safety Reporting System (JPSR) Guidebook through an independent review of the JPSR Foundations for Patient Safety Professionals (PSP) presented by the National Center for Patient Safety (NCPS). Additionally, the facility PSMs are also scheduled to attend the virtual February 2026 NCPS Foundations for Patient Safety Professionals JPSR session(s). A monthly review process has been established to evaluate all rejected JPSRs, ensuring that rejections are appropriately justified and comply with VHA guidance. This review will be conducted by a multidisciplinary group within Quality, Safety, and Value (QSV) during the Patient Safety and Risk Management huddle. The collected data will be compiled and presented to the Quality, Safety, and Value Committee (QSVC) quarterly. Closure of this recommendation will be requested once 90% compliance is sustained for two consecutive quarters.

Recommendation 6

The Richard L. Roudebush VA Medical Center Director ensures a comprehensive review of the patient's care and transfer is completed to identify factors that contributed to the patient's unnecessary transfer and takes action as warranted.

_X _Concur

____Nonconcur

Target date for completion: July 2026

Director Comments

The Quality, Safety and Value department will conduct a comprehensive review of the patient's episode of care and circumstances surrounding the transfer. The Medical Center Director will take corrective actions to mitigate any identified risk that contributes to the patient's unnecessary transfer beyond those already covered in recommendations 1–5.

Glossary

To go back, press "alt" and "left arrow" keys.

advanced cardiac life support. A set of interventions and procedures used by healthcare personnel to stabilize critically ill patients who have suffered a life-threatening event such as cardiac arrest.[1]

adverse event. "Untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm or potential harm directly associated with care or services delivered by VA providers."[2]

computed tomography angiogram (alternatively CT angiogram or simply CTA). A specialized x-ray that uses intravenous contrast materials to examine blood flow in blood vessels and produces 3D images. A CT angiogram can help locate where internal bleeding is occurring.[3]

embolization. A minimally invasive procedure performed to "stop blood flow to a specific blood vessel," often to stop excessive bleeding. A long, thin tube (catheter) is inserted through a puncture in the skin and, under image guidance, follows the path of the blood vessel to reach the treatment area, where material is released to halt blood flow.[4]

endoscopy. The use of "a scope [provider-guided video camera] that goes inside your body to take pictures or videos of organs and other structures. Healthcare providers use them to screen, diagnose and treat conditions. There are many types of endoscopy that view different organs. The most common types of endoscopy include colonoscopy, upper endoscopy and laparoscopy."[5]

fee basis. Individuals may be appointed on a fee basis to provide coverage "when health services are not otherwise readily available" and when other staffing options, such as full-time, part-time or intermittent, are not appropriate.[6]

fellow. "A physician, dentist, optometrist, chiropractor, or podiatrist in a program of accredited graduate education who has completed the requirements for eligibility for first board certification

[1] "ALS vs. BLS: Which Certification is Right for Me?," American Red Cross, accessed June 16, 2025, https://www.redcross.org/take-a-class/bls-training/difference-between-als-and-bls.

[2] VHA Directive 1004.08.

[3] UVA Health, "Computed Tomography Angiogram," accessed June 3, 2025, https://uvahealth.com/services/neuroradiology/computed-tomography-angiography.

[4] Cleveland Clinic, "Embolization," accessed June 23, 2025, https://my.clevelandclinic.org/health/treatments/23512-embolization-procedure.

[5] Cleveland Clinic, "Endoscopy," accessed August 6, 2025, https://my.clevelandclinic.org/health/diagnostics/25126-endoscopy.

[6] VA Handbook 5007, "Setting Rates of Pay Upon Appointment," updated September 30, 2011, Part II Appendix F in *Pay Administration*.

in the specialty. The term subspecialty residents is also applied to such physicians" "in approved subspecialty graduate medical education programs." A fellow, like all residents, "participates in patient care under the direction of supervising practitioners."[7]

guillotine amputation. An urgent and efficient procedure to remove an irreparably traumatized, necrotic, or severely infected limb to help stabilize an acutely ill patient without taking the time to close the surgical wound.

hemodynamic instability. A condition, also known as shock, where the body is not getting adequate blood flow.[8]

hemoglobin. A protein in red blood cells, which carry oxygen throughout the body. Low hemoglobin levels result from several conditions, including blood loss due to a condition such as a bleeding ulcer in the stomach area.[9]

hemorrhagic shock. A type of hypovolemic shock that results from heavy bleeding or blood loss, causing severe hypotension, and leaving the body unable to circulate enough blood to support the proper function of major organ systems.[10]

hypotensive or hypotension. Having low blood pressure—a reading below 90/60 mmHg. One cause of low blood pressure is insufficient blood volume, which may result from bleeding.[11]

image-guided procedures. The use of one or more of many radiology imaging modalities, such as ultrasound, x-ray, fluoroscopy, CT scan, or MRI, to navigate an instrument to a target area within the body, rather than by direct vision as is often done in conventional open surgical procedures.

infrastructure. "Physicians, nursing, other medical personnel, space, equipment, supplies, sterile processing, and other support services related to an invasive procedure."[12]

inpatient complex. Requires 24/7 critical care services that provide "daily multidisciplinary rounds, specialized technology and board-certified specialists depending on the approved

[7] VHA Directive 1400.01, *Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents*, November 7, 2019.

[8] Cleveland Clinic, "Hemodynamics," accessed June 11, 2025, https://my.clevelandclinic.org/health/body/24013-hemodynamics.

[9] Cleveland Clinic, "Low Hemoglobin," accessed June 16, 2025, https://my.clevelandclinic.org/health/symptoms/17705-low-hemoglobin.

[10] University of Utah, "What is Hemorrhagic Shock? Understanding the Basics and Its Implications," accessed June 11, 2025, https://cvrti.utah.edu/what-is-hemorrhagic-shock-understanding-the-basics-and-its-implications/.

[11] Cleveland Clinic, "Low Blood Pressure (Hypotension)," accessed June 11, 2025, https://my.clevelandclinic.org/health/diseases/21156-low-blood-pressure-hypotension.

[12] "VHA Invasive Procedure Complexity for Surgical Programs," VHA.

invasive programs, dedicated in-house 24/7 coverage of invasive patients and a readily available OR call team for emergency and salvage procedures."[13]

institutional disclosure. "A formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."[14]

intubation, or more specifically, **endotracheal intubation.** The process whereby a breathing tube, called an endotracheal tube, is guided through the mouth (typically) and into the windpipe (trachea). The tube will keep the airway open to allow oxygen delivery to, and ventilation of, the lungs. The procedure may be done as part of routine anesthesia care or urgently for many reasons, including unconsciousness, respiratory insufficiency, or cardiac arrest.[15]

issue brief. A notification from a facility to VHA Central Office of incidents that may impact a patient's ability to receive quality care. Additionally, an issue brief can be used by the VISN to share other information with VHA Central Office.[16]

myocardial infarction. A heart attack. An acute episode where death or damage of heart muscle happens due to insufficient blood supply caused by blocked coronary arteries.[17]

nonvascular. "Not of, relating to, involving, caused by, or supplied with blood vessels."[18]

sepsis. "A life-threatening medical emergency caused by [the] body's overwhelming response to an infection." The immune system "starts damaging [the body's] normal tissues and organs, leading to widespread inflammation," organ failure, and possibly death. Bacterial infection is a common cause of sepsis. In some cases, surgery may be needed to remove infected tissue to facilitate resolution of sepsis.[19]

step-down unit. An area of a hospital that provides a level of care "between that of the general ward and the intensive care unit." These units "may be used to provide a higher level of care for patients deteriorating on a ward ("step up"), a lower level of care for patients transitioning out of

[13] VHA Directive 1220(1).

[14] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[15] Cleveland Clinic, "Intubation," accessed June 12, 2025, https://my.clevelandclinic.org/health/articles/22160-intubation.

[16] VHA, "Enterprise Issue Reporting System Guide to VHA Issue Briefs," June 22, 2024.

[17] *Merriam-Webster.com Dictionary,* "myocardial infarction," accessed September 15, 2025, https://www.merriam-webster.com/dictionary/myocardialinfarction.

[18] *Merriam-Webster.com Dictionary*, "Nonvascular," accessed April 3, 2025, https://www.merriam-webster.com/dictionary/nonvascular.

[19] Cleveland Clinic, "Sepsis," accessed June 12, 2025, https://my.clevelandclinic.org/health/diseases/12361-sepsis.

intensive care ("stepdown") or a lateral transfer of care from a recovery room for postoperative patients."[20]

vascular. Arteries and veins that carry "blood and lymph fluid through the body."[21]

vasopressor infusion. The intravenous route of delivery of a medication used to raise the blood pressure of a patient whose blood pressure is too low, to better distribute blood to vital organs.[22]

[20] Meghan Prin and Hannah Wunsch, "The Role of Stepdown Beds in Hospital Care," *American Journal of Respiratory and Critical Care Medicine* 190, no. 11 (August 27, 2014): 1210-1216, https://doi.org/10.1164/rccm.201406-1117PP.

[21] Johns Hopkins Medicine, "Overview of the Vascular System," accessed April 3, 2025, https://www.hopkinsmedicine.org/health/conditions-and-diseases/overview-of-the-vascular-system.

[22] Cleveland Clinic, "Vasopressors," accessed June 12, 2025, https://my.clevelandclinic.org/health/treatments/23208-vasopressors.

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