Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Denial of Care and Lapse in Courtesy, Louis Stokes VA Medical Center Cleveland, Ohio

Report No. 06-02010-197 **August 22, 2006**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The Department of Veterans Affairs, Office of Inspector General, Office of Healthcare Inspections conducted an inspection to determine the validity of allegations of denial of care and lapse in courtesy at the Urgent Care Clinic, Wade Park Division, Louis Stokes VA Medical Center, Cleveland, OH.

We did not substantiate the allegation of denial of care. The complainant, a military reservist, alleged that physicians at the medical center denied care when they did not admit a fellow reservist (the patient) that he escorted to the medical center. An active duty psychologist at Ft. Knox, KY, evaluated the patient for fitness for duty and wanted to admit the patient for further examination; but the patient, as a reservist not on active duty, was not eligible for admission. Because the patient had been in the medical center domiciliary for the Homeless/Vocational program in 2001, the psychologist referred the patient to the medical center for either inpatient or outpatient treatment. The complainant alleged that military regulations require the medical center to admit a reservist, if requested by the command unit.

We found the Urgent Care Clinic internist completed a thorough physical and referred the patient to psychiatry for a mental health examination. The patient had a complete psychiatric examination and was determined to be stable, with no suicidal or homicidal ideation. The patient refused voluntary admission and the treating physicians determined that the patient did not meet criteria, per medical center policy, for an involuntary admission. The patient voluntarily returned for further evaluation and treatment and was subsequently admitted for assistance with homelessness and employment. Military regulation states that a mental health care provider with hospital admitting privileges is solely responsible for making the decision to admit a military service member.

We did not substantiate the allegation of lapse in courtesy. The complainant stated the patient had to be admitted; he felt the VA psychiatrist was “partially rude” because he did not follow command referral to admit the patient. The complainant was not able to give specific examples of rude behavior, but thought it was rude to ignore military authority. Interviews of clinical staff did not substantiate that the psychiatrist was rude or discourteous during this, or any other, encounter.

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

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

TO: Director, Veterans Integrated Service Network (10N10)

SUBJECT: Healthcare Inspection – Alleged Denial of Care and Lapse in Courtesy, Louis Stokes VA Medical Center, Cleveland, OH

1. Purpose

The Department of Veterans Affairs, Office of Inspector General, Office of Healthcare Inspections conducted an inspection to determine the validity of allegations of denial of care and lapse in courtesy at the Urgent Care Clinic, Wade Park Division, Louis Stokes VA Medical Center, Cleveland, OH.

2. Background

The Louis Stokes VA Medical Center (the medical center) is a tertiary care facility providing medical, surgical, psychiatric, and domiciliary services for veterans in the Cleveland area. The medical center is part of Veterans Integrated Service Network (VISN) 10 and has two divisions, Wade Park and Brecksville. It is affiliated with the Case Western Reserve University School of Medicine and provides care to over 71,000 veterans each year in northern OH.

The complainant, a military reservist, alleged that physicians at the medical center denied care when they did not admit a fellow reservist (the patient) that he escorted to the medical center. The complainant alleged that military regulations require the medical center to admit a reservist, if requested by the command unit. The complainant further alleged that the treating psychiatrist was rude.

The patient had a history of homelessness, unemployment, and an unkempt physical appearance when reporting to military reserve duty. Because of that history, the military reserve unit directed the patient to undergo a mental health examination to determine his fitness for duty. On April 10, 2006, the active duty psychologist at the behavioral health clinic in Ft. Knox, KY, evaluated the patient. The psychologist wanted to admit the patient for further examination; but, as a reservist not on active duty, he was not eligible for admission. The psychologist recommended referral to the medical center for either

inpatient care or outpatient treatment. The patient had been in the medical center domiciliary for the Homeless/Vocational program in 2001. On April 11, the complainant escorted the patient to the Urgent Care Clinic at the medical center for a mental health evaluation and possible admission.

3. Scope and Methodology

We conducted phone interviews with medical center physicians and the Urgent Care Clinic triage nurse. We reviewed local and Veterans Health Administration policies and procedures, patient medical records, and military regulations. We conducted phone interviews with military reserve staff including the complainant, the unit commander, and the unit administrative personnel. We conducted the review in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

4. Inspection Results

Issue 1: Denial of Care

We did not substantiate the allegation of denial of care.

On April 11, an internist in the Urgent Care Clinic initially evaluated the patient. During the medical exam, the patient was cooperative, denied depression, delusions, or hallucinations, and did not have suicidal or homicidal ideation. The internist determined the patient was medically stable and requested a psychiatric consult for further evaluation and disposition. A psychiatrist evaluated the patient that same day and noted that the patient was pleasant, cooperative, and engageable. The psychiatrist further noted that the patient's thoughts were logical, organized, coherent, and that the patient did not have suicidal or homicidal ideation.

The medical center policy states that certain patients who pose a threat to themselves or others will be asked to voluntarily undergo treatment; if they decline necessary treatment they will be hospitalized involuntarily. The psychiatrist offered the patient a voluntary admission but the patient declined inpatient treatment. Since the patient was examined and determined to be stable with no suicidal or homicidal ideation, he could not be admitted involuntarily per medical center policy.

The patient agreed to return the next day for outpatient evaluation and treatment and was discharged from the Urgent Care Clinic. The patient voluntarily returned to the medical center the next day and agreed to be admitted at that time.

We reviewed the military regulation for command-directed mental health evaluations. The regulation states "the final decision to admit a Service member rests solely with a

mental health care provider granted hospital admitting privileges. If a mental health care provider is not available, the member may be admitted by any health care provider with admitting privileges."[1]

We concluded that treating physicians conducted thorough physical and mental health examinations and followed medical center policy and procedure. The patient did not meet criteria for involuntary admission.

Issue 2: Lapse in Courtesy

We did not substantiate the allegation of lapse in courtesy. The complainant alleged the VA psychiatrist was rude to him on April 11, 2006, when he brought the patient to the medical center for admission.

During our interview with the complainant, he stated the patient had to be admitted and he felt the psychiatrist was "partially rude" because he did not follow command referral to admit the patient. The complainant was not able to give specific examples of rude behavior, but thought it was rude to ignore military authority. Interviews of clinic staff did not substantiate rudeness or a lapse in courtesy by the psychiatrist during this encounter. The psychiatrist's supervisor told us that he had never received any complaints from patients or staff about the psychiatrist.

5. Conclusion

The internist completed a thorough physical and referred the patient to psychiatry for a mental health examination. The patient refused voluntary admission, and treating physicians determined that the patient did not meet criteria for an involuntary admission. Later the patient voluntarily returned for further evaluation and treatment and was subsequently admitted for assistance with homelessness and employment.

6. Recommendations and Comments

We made no recommendations. The Medical Center Director and the VISN 10 Director concurred with the report findings and conclusions. See Appendixes A and B (pages 4 and 5) for their comments.

(original signed by:)

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

[1] Command-Directed Mental Health Evaluations. MEDCOM Regulation No. 40-38, June 1, 1999.

Appendix A

Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 6, 2006

From: Acting Director, Veterans Integrated Service Network (10N10)

Subject: **Healthcare Inspection Alleged Denial of Care and Lapse in Courtesy Urgent Care Clinic, Louis Stokes VA Medical Center, Cleveland, OH**

To: Assistant Inspector General for Healthcare Inspections

I concur with the findings of this report.

(original signed by:)

JOHN E. BARILICH, MSW, MBA

Appendix B

Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 20, 2006

From: Director, Louis Stokes VA Medical Center (541/00)

Subject: **Healthcare Inspection Alleged Denial of Care and Lapse in Courtesy Urgent Care Clinic, Louis Stokes VA Medical Center, Cleveland, OH**

To: Assistant Inspector General for Healthcare Inspections

1. We have reviewed the report and concur with your findings.

2. If you have any questions, please contact Ericka Mattis, Staff Assistant, at 216/791-3800, ext. 5892.

(original signed by:)

WILLIAM D. MONTAGUE

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Virginia L. Solana, Director, Kansas City Regional Office (816) 426-2023
Acknowledgments	James E. Seitz Jerome Herbers Dorothy Duncan Marilyn Stones

Appendix D

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