Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Quality of Care and Problems with Services VA Gulf Coast Veterans Health Care System Biloxi, Mississippi

Report No. 12-02612-141 March 19, 2013

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted a review at the request of Congressman Jo Bonner to assess allegations concerning a patient's quality of care as well as address problems with services at the VA Gulf Coast Veterans Health Care System (facility), in Biloxi, MS. The complainant alleged that:

- Emergency department (ED) physicians did not perform a complete medical evaluation during three of four visits.
- A Mobile Community Based Outpatient Clinic (Mobile CBOC) primary care provider (PCP) did not assess the patient's chronic back pain.
- A Mobile CBOC PCP did not return family members' telephone calls.
- Telephone service at the Mobile CBOC was problematic.
- Durable medical equipment (DME) was not delivered timely.
- Payment was [erroneously] denied for a non-VA hospital stay.
- Facility staff had difficulty coordinating the patient's discharge plans.

We substantiated that during one of four ED visits, the March 2012 visit, the patient's overall medical evaluation did not meet VHA standards. Although not one of the complainant's allegations, we found the facility did not conduct a peer review of the ED physician's care. We substantiated the allegation that telephone service at the Mobile CBOC was problematic. We substantiated the allegation that payment for a non-VA hospital stay was originally denied; however, during the course of this review, was revisited by the facility and the Veterans Integrated Service Network 16 staff, and a decision was made to pay the non-VA hospital stay.

We did not substantiate the allegation that a PCP did not address the patient's chronic back pain at the Mobile CBOC. We did not substantiate the allegation that the patient did not receive timely delivery of the DME. In fact, the facility policy requires patients to pick up their DME, and the patient was timely notified that the DME was available for pick-up. We also did not substantiate the allegation that facility staff had difficulty coordinating the patient's discharge plans. Due to insufficient documentation, we could neither confirm nor refute the allegation that the Mobile CBOC PCP received any telephone calls from the patient's family members during the months of January, February, or March 2012.

We recommended that the facility Director ensure that a quality of care review is conducted with specific attention to the deficiencies identified in this report. We also recommended that the facility Director strengthen processes to address patient complaints regarding the automated telephone system at the Mobile CBOC.

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

TO: Director, South Central VA Health Care Network (10N16)

SUBJECT: Healthcare Inspection – Alleged Quality of Care and Problems with Services, VA Gulf Coast Veterans Health Care System, Biloxi, Mississippi

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the request of Congressman Jo Bonner to assess allegations concerning a patient's quality of care and problems with services at the VA Gulf Coast Veterans Health Care System (facility) in Biloxi, MS.

Background

The facility is part of Veterans Integrated Service Network (VISN) 16 and serves over 59,000 veterans. The facility provides inpatient medical, surgical, mental health, geriatric, and rehabilitation services, and outpatient primary care, and operates four Community Based Outpatient Clinics (CBOCs), one located in Alabama and three in Florida.

On April 19, 2012, the OIG received a Congressional inquiry regarding the quality of care a patient received and problems with services.

The complainant alleged that:

- Emergency department (ED) physicians did not perform a complete medical evaluation during three of four visits.
- A Mobile, AL, CBOC (Mobile CBOC) primary care provider (PCP) did not assess the patient's chronic back pain.
- A Mobile CBOC PCP did not return family members' telephone calls.
- Telephone service at the Mobile CBOC was problematic.
- Durable medical equipment[1] (DME) was not delivered timely.
- Payment was [erroneously] denied for a non-VA hospital stay.
- Facility staff had difficulty coordinating the patient's discharge plans.

[1] Durable medical equipment (DME)-reusable medical equipment used in the home to aid in the activities of daily living

Scope and Methodology

We reviewed quality of care issues within the VA for care provided to the patient during PCP visits between 2007–2012, facility ED visits from January–March 2012, and facility inpatient care between January–February 2012. We also reviewed non-VA care, as relevant, during January–April 2012.

We conducted a site visit on September 25–27, 2012. We conducted interviews with clinical and administrative staff with direct knowledge of the patient's care. We also conducted telephone interviews with the complainant and the patient. We reviewed the patient's medical record and non-VA hospital billing documents, facility daily financial reports, patient advocate reports, and relevant Veterans Health Administration (VHA) and local policies. We also examined internal administrative reviews conducted by the facility as related to the patient's quality of care.

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

Case Summary

The patient is a male in his late sixties whose chronic medical conditions include low back pain and splenectomy[2] due to war-related injuries in the 1960's. Prior to January 2012, he maintained an active daily routine including work on his farm.

In January 2012, the patient presented to the facility's ED complaining of severe low back pain. The ED physician (Physician A) cited the patient's history of chronic back pain and described the current presentation as "in excess of the usual." Other than mental status, no neurologic examination was performed by Physician A, but the back was described as painful with movement and "tender to any palpation in the right [lower back] area." No laboratory or imaging data was obtained or recommended. The patient's acute pain was felt to be due to severe muscle spasm. Following a single injection of a narcotic, he was discharged to home, advised to rest, use a muscle relaxant as necessary, and see his PCP as follow-up. The patient was also advised to return to the ED for "loss of bowel or bladder control."[3]

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[2] A splenectomy is a surgical procedure to remove the spleen, an abdominal organ located under the left rib cage.
[3] Patients with back pain who experience sudden bladder and/or bowel incontinence (dysfunction that causes retention of urine, inability to hold urine, or loss of rectal control) should seek immediate medical attention. These symptoms may be caused by a severe compression of the nerve sac in the lower spine, a condition known as cauda equina syndrome.

The next day, the PCP's nurse telephoned the patient to inquire as to his condition since being seen in the ED the prior day. While the patient indicated he was still experiencing severe back pain and "having difficulty getting around", a family member offered that the patient "had lost some of his bladder function." The patient was advised to "present to the ED immediately." Triage assessment cited the patient as experiencing pain so intense as to make him unable to get to the restroom. The ED physician (Physician B) acknowledged the patient's history of chronic low back pain and the recent acute flare resulting in the ED visit of the prior day. Physician B's neurologic examination documented an abnormality of decreased sensation in a lower extremity. No laboratory or imaging data was obtained or recommended. Physician B's clinical impression was of "lumbar radiculopathy."[4] The patient received a single injection of narcotic which partially relieved his back pain, a prescription for a 10-day supply of an oral narcotic agent, and was discharged to home.

One week later, the patient again presented to the facility's ED, brought in by family members for altered mental status, numbness of a lower extremity, and impaired gait. He was again seen by Physician A, who noted him to be confused and disoriented, with a rapid heart rate and rapid respiratory rate. A complete blood count (CBC)[5] was obtained and revealed a markedly elevated white blood cell count (WBC).[6] A catheter was inserted into the bladder to obtain a urine specimen, and the bladder was decompressed of 1400 ml of urine.[7] Physician A's diagnoses included sepsis,[8] dehydration,[9] urinary retention,[10] rapid atrial fibrillation,[11] and the patient was admitted to the facility's intensive care unit (ICU). The patient was confirmed to have bacteria present in the bloodstream (staphylococcus aureus)[12] and was suspected of having septic emboli in the

[4] Lumbar radiculopathy-a nerve in the lower spine is compressed or irritated as it exits the spine due to a reduced amount of space in the spinal canal or pressure from adjacent structure(s).
[5] A complete blood count (CBC) is a test that gives information about the kinds and numbers of cells in a person's blood, especially red blood cells, white blood cells, and platelets.
[6] A white blood cell (WBC) elevation may indicate an infection, inflammation, or other stress on the body.
[7] The urge to urinate typically is sensed when the bladder contains 200–400 ml urine; a bladder containing 600–800 ml urine would be completely full and, if neurologically intact, additional volume would generally cause considerable discomfort.
[8] Sepsis is the presence of pathogenic organisms, usually bacteria, in the bloodstream triggering inflammation throughout the body.
[9] Dehydration is a condition where the body lacks normal amounts of water.
[10] Urinary retention is a condition caused by an obstruction in the urinary tract or nerve problems that interfere with signals between the brain and bladder. For example, if the nerves to the bladder are not working properly the brain may not get the message that the bladder is full.
[11] Atrial fibrillation is a common type of abnormal heartbeat in which the heart rhythm is fast and irregular.
[12] Staphyloccus aureus is a type of bacteria that can infect various body tissues producing mild to severe disease. Although anyone can develop a staphylococcal infection, patients with weakened immune systems are at an increased risk.

lungs.[13] The source of the septic emboli was felt most likely to be infection in the heart tissue, endocarditis.[14]

Due to the complexity of the case, the need for specialized echocardiogram,[15] and further infectious diseases subspecialty support, the patient was transferred to a nearby military medical center on hospital day three. There, he was confirmed to have endocarditis caused by staphylococcus aureus.

Following evaluation and initial management at the military medical center, a military case manager contacted a facility case manager one week later, indicating the patient no longer was requiring specialized care and was "ready to transfer back to the facility" for further routine care. The facility's case manager documented the patient's status in the electronic health record (EHR) and forwarded electronic records to the Chief, Medical Service (COM) for review and action. No electronic signature, or other acknowledgement of the case manager's request for accepting the patient back in transfer, was forthcoming by the COM for seven days. The COM confirmed to us that he was present at the facility on every working day during February 2012. In the meantime, further appeals to approve the patient's transfer back to the facility were made to physician leadership by VA case managers through telephone calls, electronic mail, and morning report conferencing. While bed space was documented as available at the facility at the time of the request for transfer, physician approval was not obtained over the course of eight days. Lacking success in the multiple efforts to transfer the patient back from the military medical center to the facility, the patient's family made the decision eight days later, to have him transferred to a non-VA rehabilitation center. Two weeks later, the patient was discharged to home to complete three additional weeks of intravenous antibiotic therapy utilizing a peripherally inserted central catheter line (PICC)[16] for management of endocarditis.

Upon discharge from the non-VA rehabilitation center, the patient required several types of DME to include a wheelchair, walker, cane, bedside commode, and shower seat. The DME was ordered on the day the patient was discharged from the non-VA rehabilitation center, and five days later, the patient was notified to pick up the DME from the facility.

After completing a 6-week course of intravenous antibiotic therapy for endocarditis the patient experienced a day of relatively normal activity and no pain. However, he awakened during the following night, with "horrible pain" again localizing to the low

[13] Septic emboli-is the migration of pieces of infected tissue from one part of the body to another, via the bloodstream, frequently originating from bacterial infection in the heart tissue.
[14] Endocarditis is an inflammation, often from infection, of the inside lining of the heart chambers and/or heart valves.
[15] An echocardiogram is a test that uses sound waves to create a moving picture of the heart; it is utilized in many clinical circumstances including assessing for infection of the heart tissues.
[16] A peripherally inserted central catheter (PICC) line is a flexible tube inserted into a peripheral vein, usually in the upper arm, and advanced until the line's tip is in a large vein near the heart. A PICC line is often utilized as a way of obtaining access to the bloodstream to administer prolonged courses of medications such as antibiotics.

back. He returned to the facility's ED that morning, and was seen again by Physician A. In assessing the patient's chief complaint of "back pain", Physician A documented the history of chronic back pain with the recent worsening but cited the present pain as distinct from that of the prior month. On physical examination, the patient was described as having "difficulty sitting up unaided" and as experiencing "tremendous exacerbation [of pain] with even trying to sit-up, aided or not."

Although this splenectomized patient had just completed a multi-week course of antibiotics 48 hours earlier for systemic infection, no laboratory or imaging data was obtained or recommended in the ED on that visit. The patient received a single injection of narcotic, noted improvement in his pain, and was discharged to home with instructions to rest and use narcotic analgesia as needed for 48 hours, and to follow-up with his PCP as needed, or to return to the ED "in the event the condition worsens."

Due primarily to the persistence of severe back pain, generalized weakness, and the family's disillusionment with care at the facility's ED, the patient presented to a non-VA hospital's ED the next day. There, he was described as "appearing weak" and found to have an elevated WBC of 17,600 K/cmm,[17] and a marked increase in erythrocyte sedimentation rate (ESR) at 110 mm/hr.[18] He was admitted to the non-VA hospital that day and again determined to be septic (with multiple blood cultures growing the same organism with which he had previously been infected, staphylococcus aureus). An echocardiogram did not show evidence of recurrent endocarditis but MRI imaging[19] of the painful region in the low back was interpreted as showing extensive epidural abscesses[20] (involving the entire lumbar spine) and vertebral osteomyelitis.[21] The patient remained at the non-VA hospital and promptly underwent extensive neurosurgery to decompress infectious material (pus) at multiple spinal levels of the low back. The spinal abscesses were demonstrated to be due to staphylococcus aureus, the same organism causing the patient's recent endocarditis. The patient had another PICC line placed and required a second course of extended antibiotic therapy (8 weeks).

Since the completion of the antibiotic therapy in May 2012, the patient has made a slow, steady recovery. He describes his stamina and weight as not yet at baseline but improving gradually as he attempts to resume home and farm activities as he is able.

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[17] A normal WBC range is defined at the facility's laboratory as 4,800–10,800 K/cmm.
[18] An erythrocyte sedimentation rate (ESR) is a non-specific but sensitive blood test that, when increased over the baseline value of 0–20 mm/hr, often reflects the presence of inflammation, such as from infection.
[19] Magnetic Resonance Imaging (MRI) is an imaging technique used to visualize internal structures of the body in detail.
[20] Epidural abscess-a collection of pus, usually caused by bacteria, between the outer covering of the spinal cord and the bones of the spine.
[21] Vertebral osteomyelitis-an infection affecting bone tissue in the spinal region.

Inspection Results

Issue 1. Quality of Care

Alleged Substandard Medical Evaluation in the ED

We did not substantiate the allegation that the patient's medical evaluation in the ED was substandard for visits on three January visits. We found that on these dates the facility met VHA standards.

We substantiated the allegation that an ED physician's overall medical evaluation and documentation of the patient's presenting clinical condition in late March did not meet VHA standards. VHA policy[22] requires that staff document a pertinent progress note at the time of each visit with specific items to support diagnostic and treatment decisions.

Although the patient had a history of chronic back pain "for years," Physician A noted a departure from the usual level of pain on that March visit, as well as a distinction from the patient's back pain flare-up during his recently completed hospitalization. In addition, Physician A's note details an awareness that the patient had "just finished an antibiotic therapy course last week" (having had a PICC line removed 48 hours earlier). Physician A told us that he was aware of the patient having had a staphylococcal infection "during his recent (non-VA) hospitalization." Recognition of these facts, coupled with a physical examination detailing "tremendous exacerbation" of back pain when attempting to sit, even when aided, portray the patient's symptoms as unusually severe. In addition, the patient had a past history of a splenectomy. A patient without a spleen is at an increased risk of infection.

In lieu of the patient's known overall medical condition on that March visit (splenectomized, having just completed a six week course of intravenous antibiotics for systemic infection) and presentation with intense back pain shown due to widespread infection of the lower spine 3 days later, the minimal evaluation at the facility's ED on March does not comport with reasonable care.

We also found that the facility did not conduct a Peer Review for the ED evaluation of that March visit. Peer review is a non-punitive, confidential process used to evaluate care provided to patients by individual providers. According to VHA policy, the formal process of peer review involves evaluation of specific episodes of care, determination of necessary specific actions based on evaluations, confidential communication with providers, and identification of systems and process issues that may require special actions.[23] Peer review must be performed for occurrences where a patient has

[22] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
[23] VHA Directive 2010-025, para 4, item (g)5(g)2, *Peer Review for Quality Management*, June 03, 2010.

experienced an unexpected outcome that may be related to the care provided. Based on VHA peer review policy, the severe back pain ED presentation of March 2012, with subsequent hospitalization within 72 hours for widespread spinal region infection requiring prompt neurosurgical intervention and shown to be a complication of a recent systemic infection, warranted peer review.

Alleged Failure to Treat Chronic Back Pain at the Mobile CBOC

We did not substantiate the allegation that the Mobile CBOC PCP did not address the patient's chronic back pain. The EHR showed that the patient's pain level was repeatedly assessed during Mobile CBOC primary care visits from 2007–2011, and the PCP had prescribed pain medication, physical therapy, and recommended a neurosurgery consult (which the patient had declined). The patient's longstanding, chronic back pain was due to military trauma many years ago, was non-infectious, and stands in distinction to the debilitating back pain prompting the ED visits of early 2012, ultimately shown to be due to spinal region infection.

Issue 2: Problems with Services

Alleged Failure to Return Family Member's Telephone Calls at the Mobile CBOC

We could not confirm or refute the allegation that the patient's family members telephoned the Mobile CBOC PCP during the months of January, February, or March 2012. The complainant did not provide specific information regarding the dates and times of the telephone calls. In addition, the patient's EHR did not show documentation of telephone calls from any family members during these months.

Alleged Problems with Telephone Service

We did substantiate the allegation that the telephone service was problematic at the Mobile CBOC. Facility and Mobile CBOC staff reported being aware of the complaints regarding the automated telephone system. We also found documentation of complaints regarding the automated telephone system in the patient advocate's reports. CBOC leadership are aware of the problem.

Alleged Delay in Delivering DME

We did not substantiate the allegation that the patient did not receive timely delivery of DME. The DME was ordered on the day he was discharged from the non-VA rehabilitation center and five days later, the patient was notified to pick up the DME from the facility. According to facility policy, patients are required to pick up DME from the facility. Review of the EHR revealed the patient picked up the DME one week after notification.

Alleged [Erroneous] Denial of Payment for a Non-VA Hospital Stay

We substantiated the allegation that payment for a non-VA hospital stay was denied by the facility. However, during the course of this review, the facility and VISN 16 staff revisited this issue and a decision was made to pay the non-VA hospital stay.

Alleged Difficulty Coordinating Patient's Discharge Plans

We did not substantiate the allegation that it was difficult to coordinate the patient's discharge plan from a non-VA rehabilitation center. We reviewed documents from the non-VA rehabilitation center and the patient's EHR. We found documentation of communication between the non-VA rehabilitation center and the facility regarding the patient's discharge plans. We also found documentation that home health and pharmacy services were set-up prior to discharge.

Conclusions

We substantiated that the patient received substandard care during his ED visit in late March 2012. The ED physician documented extraordinary lower back pain, suggesting a departure in level of pain from the patient's baseline, as well as from recent, back pain. Although the patient had recently completed an extended course of antibiotics for systemic infection and was immune compromised (splenectomy), no consideration was made as to a possible infectious cause. Within 3 days, the patient was admitted to a non-VA hospital and promptly determined to have widespread infection of the lower spine region requiring extensive neurosurgery. No quality review was conducted to address any aspect of the patient's ED care in late March.

Other episodes of care considered in the course of this review, whether in the facility's ED, inpatient system, or at the Mobile CBOC, did comport with reasonable quality and VHA standards. We did not substantiate that it was difficult to coordinate the patient's discharge planning from a non-VA rehabilitation center.

We substantiated that the ability of patients and family members to contact providers by telephone at the Mobile CBOC is often difficult. The CBOC is aware that telephone access is not presently efficient. However, we could not confirm or refute that a specific CBOC PCP did not return family members' telephone calls.

We did not substantiate a delay in DME delivery as availability was timely made to the patient and facility policy does not require delivery but, rather, patient pick-up.

Recommendations

Recommendation 1. We recommended that the facility Director ensure that a quality of care review is conducted with specific attention to the deficiencies identified in this report.

Recommendation 2. We recommended that the facility Director strengthen processes to address patient complaints regarding the automated telephone system at the Mobile CBOC.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes A and B, pages 10–12 for the Director's comments.) We will follow up on the planned actions until they are completed.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 4, 2013

From: Director, South Central VA Health Care Network (10N16)

Subject: **Healthcare Inspection – Alleged Quality of Care and Problems with Services, VA Gulf Coast Veterans Health Care System, Biloxi, MS**

To: Director, Chicago Office of Healthcare Inspections (54CH)

Attached is the response to the Health Inspection Report for VA Gulf Coast Veterans Health Care System, Biloxi, MS, for the review conducted September 25-27, 2012. As requested, the response includes a plan of action and target completion dates for each recommendation.

If you have any questions, please contact Myrtle Tate, VISN 16 Quality Management Officer, at (601) 206-7027.

MHA, FACHE

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 1, 2013

From: Director, VA Gulf Coast Veterans Health Care System (520/00)

Subject: **Healthcare Inspection – Alleged Quality of Care and Problems with Services, VA Gulf Coast Veterans Health Care System, Biloxi, MS**

To: Director, South Central VA Health Care Network (10N16)

I concur with the draft report and recommendations made as a result of the Health Inspection review conducted at VA Gulf Coast September 25-27, 2012.

Action to address both recommendations has been initiated with a targeted completion date of May 31, 2013, for Recommendation 1 and July 31, 2013, for Recommendation 2.

Anthony L. Dawson, MN

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

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

OIG Recommendations

Recommendation 1. We recommended that the facility Director ensure that a quality of care review is conducted with specific attention to the deficiencies identified in this report.

Concur **Target Completion Date: May 31, 2013**

Facility's Response:

The VISN and Medical Center Directors agree with the findings and recommendation. A quality of care review (Peer Review) will be conducted to address the quality of care issue identified for the March 2012 visit to the Emergency Department.

Recommendation 2. We recommended that the facility Director address patient complaints regarding the automated telephone system at the Mobile CBOC.

Concur **Target Completion Date: July 31, 2013**

Facility's Response:

The VISN and Medical Center Directors agree with the findings and recommendation. To improve our telephone responsiveness and access to care, VA Gulf Coast is implementing a "Call Center" in July 2013. The Call center will receive incoming calls from Veterans and other stakeholders to facilitate patient care needs. The Call Center will be staffed with Medical Administrative Assistants, Pharmacy Technicians, and Nurses, who will answer calls, screen for emergent issues, resolve patient care needs, and ensure a proper hand-off of information to providers, patient care teams, and services across the Health Care System.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Thomas Jamieson, MD, Project Leader Laura Spottiswood, RN, Team Leader Sheila Cooley, MSN, RN Wachita Haywood, RN Judy Brown, Program Support Assistant

Appendix D

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