Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-01467-256

Healthcare Inspection

Coordination and Delivery of Medical Care Concerns
VA Black Hills Health Care System
Fort Meade, South Dakota

August 20, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
Web site: www.va.gov/oig

Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted a review in response to allegations received by Senator Tim Johnson's office concerning poor coordination and delivery of care at the VA Black Hills Health Care System (system), Fort Meade, SD.

We were unable to substantiate the allegation that the telephone contact and triage process in place during 2012 was cumbersome, resulted in delayed responses from primary care providers to patients calling for medical care or advice, or was set up to divert calls away from primary care providers.

We did not substantiate the allegation that a veteran's spouse received inaccurate information on obtaining emergency care outside of the system. The staff at the system followed the system policy when providing information on where to take the veteran for care.

We did not substantiate the allegation of "negligence and medical errors" at the system during the veteran's evaluation and subsequent admission in November 2012. Review of the electronic health records showed appropriate care of the veteran's symptoms as they developed.

We did not substantiate the allegation that VA did not make the veteran aware of all alternatives to care related to podiatry concerns. The veteran was seen by system podiatrists and treated appropriately. Referrals were made for non-VA care when indicated.

We did not substantiate the allegation that a veteran's spouse was denied care because of difficulty coordinating care under the Civilian Health and Medical Program of the Department of Veterans Affairs—CHAMPVA. The spouse chose to use non-VA care, when VA providers were available. VA does not fill prescription medications for CHAMPVA patients who receive care from non-VA providers.

We made no recommendations.

Comments

The Acting Veterans Integrated Service Network and System Directors concurred with the report. (See Appendixes A and B, pages 11–12 for the Directors' comments.)

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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review in response to allegations received by Senator Tim Johnson's office concerning poor coordination and delivery of medical care at the VA Black Hills Health Care System (system), Fort Meade, SD. The purpose of this review was to determine if the allegations had merit.

Background

The system is part of Veterans Integrated Service Network (VISN) 23 and has divisions at Fort Meade and Hot Springs, SD. The system provides primary and secondary medical and surgical care, residential rehabilitation treatment program services, extended nursing home care, and tertiary psychiatric inpatient care. The system has sharing arrangements with Ellsworth Air Force Base, the South Dakota National Guard, and other community partners as well as affiliations with the University of South Dakota School of Medicine, South Dakota State University Nursing and Pharmacy Programs, and Western Dakota Technical Institute. The system also maintains affiliations with a variety of other disciplines including podiatry. The Fort Meade division has an emergency department (ED), medical/surgical beds, a medical/surgical intensive care unit, mental health beds, and two community living centers. The Hot Springs division has an urgent care center (UCC) that is open 24 hours a day, 7 days a week and provides inpatient acute medical and community living center patient services; however, it does not provide surgical care. Primary care is provided through a patient aligned care team (PACT) consisting of a provider, a Registered Nurse (RN) case manager, a Licensed Practical Nurse, and a clerk. The Fort Meade division has five PACTs, and the Hot Springs division has three PACTs.

In January 2014, the OIG received a congressional request to review allegations regarding poor coordination and delivery of medical care at the system. Specifically, the allegations stated that:

- The system in place for patients to contact their primary care provider (PCP) is cumbersome, results in delayed responses from the PCP to the patient, and is set up to divert calls away from the PCP.
- The spouse of a veteran was given inaccurate information regarding emergency medical care outside of the system when calls were made to the system in November 2012.
- A veteran who received care from providers and nursing staff at the system in November 2012 experienced "negligence and medical errors."
- VA did not make the veteran aware of all alternatives to care related to podiatry concerns.
- The system denied care to a veteran's spouse through Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

Scope and Methodology

We interviewed the complainants prior to a site visit on February 26–27, 2014. During our site visit, we interviewed leadership, managers, RNs, PACT team members, and other staff with information relevant to the allegations.

We reviewed pertinent electronic heath record (EHR) and non-VA hospital records. We also reviewed relevant VHA and system policies, Patient Advocate Tracking System data, incident reports, root cause analyses, Joint Commission reviews for cause, peer reviews, and tort claims for fiscal year 2013.

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 veteran is in his early 70s with chronic medical issues including rheumatoid arthritis, scarring of the lungs requiring oxygen use at night, high blood pressure, inflammation of the stomach lining, and a heart attack. The veteran's primary care had been provided at the Hot Springs division from 2001–2006 and at the Fort Meade division since 2007. A private rheumatologist, pulmonologist, and gastroenterologist are currently seeing the veteran utilizing non-VA care coordination, formerly known as VA fee basis care.

Review of the EHR showed that, in November 2012, the veteran presented to the UCC at Hot Springs around noon complaining of nausea, vomiting, and diarrhea that had begun the previous night. The veteran complained of back and rib pain due to continuous vomiting. The veteran had difficulty breathing at home, so the spouse had started the veteran's oxygen (prescribed for night use) at 5 liters per minute and brought the veteran to the UCC.

The RN noted in the EHR that the veteran arrived on oxygen with persistent low oxygen levels. The veteran received intravenous (IV) fluids for dehydration. The UCC provider ordered an electrocardiogram (EKG), routine blood work, blood cultures, an arterial blood gas,[1] and a portable chest x-ray.

Respiratory therapy personnel reduced the oxygen flow to 3 liters per minute based on the arterial blood gas results, and the veteran's oxygen level subsequently improved. The veteran received antibiotic and anti-nausea medications per IV while in the UCC. The UCC provider documentation indicated the veteran complained of nausea, vomiting, and shortness of breath but had no complaints of chest pain, new muscle or joint pain, nerve tingling, or arm or leg numbness. The UCC provider admitted the veteran with the diagnoses of pneumonia and dehydration and instituted continuous heart rate and rhythm monitoring.

The admitting provider's EHR documentation showed that the veteran had a 24-hour history of nausea, vomiting, and diarrhea with light-headedness and bilateral mid-back and rib pain from vomiting. Per physical exam, the provider noted decreased lung sounds to both lung bases; increased heart rate with normal heart rhythm; tenderness of the lower back, spine, and bilateral ribs; a soft abdomen without tenderness; and extremities with a mild inflammatory deformity consistent with rheumatoid arthritis. The provider's assessment further noted severe dehydration that was responding well to IV fluids. The initial work-up showed the possibility of a gastrointestinal infection or pneumonia. The result of a portable chest x-ray done while the veteran was in the UCC was inconclusive for the diagnosis of pneumonia. The provider continued the IV fluids and IV antibiotics.

[1] An arterial blood gas is a test measuring oxygen and carbon dioxide levels in the blood to assist in determining how well the lungs are functioning.

After admission to the unit, the RN documented that the veteran complained of vomiting, diarrhea, and back and rib pain as well as intermittent tingling of the right hand. The nursing skin assessment documented no abnormalities. The RN noted the veteran was at high risk for falling when getting up without assistance. According to the EHR, the RN placed the veteran in a room close to the nurse's station, locked the bed in the low position, activated the bed alarm,[2] and instructed the veteran to use the call light for assistance.

The EHR documentation showed the veteran received three medications in the early evening: an oral pain medication an oral anti-diarrhea medication at 5:57 p.m., and an IV pain medication for continued pain. The RN documented that the veteran's heart rate remained high with a normal rhythm.

The RN reassessment, completed around 8:00 p.m., indicated that the veteran complained of leg pain; the RN could not feel leg pulses and noted an uneven discoloration of the skin of the right leg. Using a Doppler ultrasound device,[3] the RN was able to detect evidence of blood flow in the left leg but not in the right leg. The RN contacted the on-call provider to evaluate the veteran's leg.

The provider assessed the veteran and documented that the veteran stated the leg pain was not present on admission but began suddenly that evening. The provider determined that the veteran was possibly having an acute arterial blockage in his right leg and needed a higher level of care. The provider wrote orders for the veteran to be transferred to a non-VA hospital that offered vascular surgery services. The provider approved an additional dose of pain medication because of continued complaints of severe pain. The RN gave the additional dose of IV pain medication.

The Emergency Medical Service (EMS) staff arrived shortly after the veteran received the additional dose of IV pain medication. EMS staff documented that while they were getting information from the RN outside the veteran's room, they heard the veteran talking in the room. When EMS staff entered the room, they noted the veteran was difficult to arouse. The change in mental status was attributed to the effects of the pain medication. EMS staff consulted with the VA staff, and the veteran received a medication to reverse the effects of the pain medication. The veteran became responsive and was able to answer EMS staff questions.

The EMS ambulance left the Hot Springs division around 10:00 p.m. and transported the veteran to a non-VA hospital approximately 55 miles away. EMS staff continued oxygen, IV fluids, and heart monitoring. An EKG performed en route, showed a normal heart rhythm with an occasional extra, abnormal heartbeat. The veteran received IV pain medication while enroute for leg pain and the EMS staff noted that the patient slept during transport.

[2] A bed alarm is an alarm that sounds if the patient gets out of bed; it is used for patients who are at risk for falling when getting up without assistance.
[3] A Doppler ultrasound device uses reflective sound waves to evaluate blood flow through a blood vessel.

The ED provider at the non-VA hospital documented the veteran had a regular heart rhythm, no respiratory distress, no extremity edema, and no gross weakness upon arrival. Additionally, the EKG was interpreted as elevated heart rate with an occasional extra abnormal heartbeat. The ED provider wrote that the veteran had obvious vascular blockage in the right leg and contacted a surgeon for immediate surgical management.

The surgeon documented the veteran had advanced restricted blood flow of the right leg with most likely a blood clot in the right iliofemoral system[4] from atrial fibrillation.[5] The surgeon based his diagnosis on the physical exam. According to the EHR and other documentation, this patient did not have a history of atrial fibrillation, nor do available records indicate that atrial fibrillation was noted on EKG or telemetry monitoring. The surgeon did not order imaging studies such as a Magnetic Resonance Imaging or Computed Tomography scan with contrast media[6] because the use of contrast media may increase the risk of kidney damage, and the veteran's blood tests indicated diminished kidney function. As imaging with contrast media was not an option, the surgeon decided to take the veteran emergently to surgery in the early morning hours to explore the veteran's right groin for a possible blood clot.

The postoperative diagnosis was acute severe right lower extremity inadequate blood flow secondary to a right iliac vessel blood clot due to narrowing from plaque formation.[7] The surgeon removed the blood clot and performed an arterial bypass that returned circulation to the right leg. The surgeon also made incisions along the front and side of the leg to relieve elevated, harmful pressures, due to potential damage to the leg muscles from the lack of blood flow.

The veteran stayed at the non-VA hospital for 7 days and was discharged with orders for wound care. The system referred the veteran to a non-VA clinic for wound care and the veteran reported the leg wounds were healed in May 2013.

[4] The arterial blood supply of the legs begins with the iliofemoral system.
[5] Atrial fibrillation is a common type of abnormal heart rhythm that results in irregular heartbeat and is associated with that may block blood vessels.
[6] The use of contrast media enhances the visibility of blood vessels during medical imaging.
[7] Plaque is made of fat, cholesterol, calcium and other substances found in the blood that can build up over time inside artery walls causing blockage.

Inspection Results

Issue 1: Telephone Triage Process

We were unable to substantiate the allegation that the telephone contact and triage process in place during 2012 was cumbersome, resulted in delayed responses from PCPs to patients calling for medical care or advice, or was set up to divert calls away from PCPs.

In 2010, the system implemented a call center staffed with RNs, medical administration, and pharmacy staff. Patients can call into the center through a separate number or transfer from the main system number. The call center is used to obtain medical advice, schedule appointments, and request pharmacy refills. The call center RNs use a telephone triage program designed to facilitate access to care and provide consultation and assistance to patients and their families regarding health information, home care measures, and navigation of the system. RN calls are recorded as notes in the patient EHR.

The veteran's spouse reported making several calls to VA on the day of the veteran's admission in 2012. The spouse reports the first call was to the Hot Springs division seeking advice as the veteran was experiencing vomiting, diarrhea, and had developed difficulty breathing; the call was transferred to an RN. The RN instructed the spouse to take the veteran to the Hot Springs division for evaluation (approximately 12 miles from the veteran's home). However, the spouse wanted to speak with the veteran's PCP at the Fort Meade division to get permission to seek care from a non-VA hospital, over 40 miles away from their home. The spouse, therefore, made a second call to the Fort Meade division and reportedly left the veteran's PACT RN Case Manager a voicemail message requesting a return call. The spouse reported making a third call to the Fort Meade division and spoke to an RN from a different PACT. The RN from the different Fort Meade PACT instructed the spouse to take the veteran to the system's Hot Springs division for evaluation.

We were unable to verify the system received calls from the spouse on this day because there are no records of calls in the EHR. Additionally, the complaint is based on events that occurred in November 2012, and we could not assess how the spouse reported the calls were triaged. We interviewed triage and PACT RNs. One person interviewed expressed concern about poor job performance of an RN who had been responsible for returning patient telephone calls at the time of the alleged incident. However, this RN was no longer working at the system and could not be interviewed.

During our interviews, staff reported that calls should not be routed directly to a PCP. Instead, the call should be routed to the PACT RN Case Manager who will either respond to the issue or discuss it with the PCP. Patients may leave a voicemail for the PACT RN when the PACT RN is not available to answer a call. The system did not have a policy addressing timeframes for RNs to return calls. During our interviews, all PACT staff stated that they returned calls as their schedules allowed; the goal was to

return calls received in the morning before noon and calls received in the afternoon before leaving for the day.

We found that the PACT RN telephone audio recording instructed callers to dial 911 for medical or mental health emergencies. The call center RN also advises callers to dial 911 in an emergency or to go to the nearest hospital for evaluation if the caller is stable enough to travel by car. Depending on the caller's location, the nearest facility may be a VA or non-VA hospital.

As of summer 2013, all PACTs now provide patients with information on cards, instead of flyers, that include the toll free and local clinic telephone numbers, the call center telephone number, and the telephone extensions for the assigned PACT nurses. We were able to get our calls routed appropriately when we called the telephone system and entered the telephone extensions provided on the PACT cards.

Issue 2: Emergency Medical Care

We did not substantiate the allegation that the spouse of a veteran did not receive accurate information regarding emergency medical care outside of the system.

As noted above, the spouse reported making three phone calls to VA on the day the veteran was admitted to the Hot Springs division. According to the spouse, the Fort Meade division PACT RN who advised taking the veteran to the nearest VA facility stated the veteran would be responsible for any bills incurred at the non-VA hospital if the veteran were to go to the private facility first rather than the closest VA facility which was the Hot Springs division.

We interviewed current PACT and call center staff, and all staff stated that if a patient or spouse calls with complaints of an urgent or emergent nature, staff will instruct the patient or family to go to the nearest facility. The nearest facility may be VA or non-VA. All of the staff we interviewed would have advised the veteran or spouse to go to the Hot Springs division 12 miles away, not to an emergency room over 40 miles away. These instructions are consistent with the system's RN triage protocols and policy on non-VA care.

Issue 3: Negligent Care

We did not substantiate the allegation that the veteran experienced "negligence and medical errors" in care at the system during staff evaluations and prior to admission to a non-VA hospital in November 2012. We reviewed the veteran's EHR and interviewed relevant nursing staff. We were not able to interview four staff who participated in the veteran's care, as they no longer worked at the system.

Medical Care. The veteran arrived at the Hot Springs division UCC for evaluation approximately 3 hours after the spouse first received advice to do so. The UCC provider started treatment for dehydration, performed appropriate work-up based on the veteran's symptoms, and gave medications to fight infection and reduce nausea. The

EHR did not include documentation that the veteran had complaints of leg pain or abnormality of the skin during the UCC stay.

The admitting provider documented that the veteran's dehydration condition responded to treatment, as the veteran was no longer light-headed. The RN documented in the admission note a full skin assessment (no abnormalities noted), and the pain assessment revealed complaints of lower back and rib pain (no leg pain noted). The first documentation of a complaint of right leg pain was at 8:00 p.m. when the RN reassessed the veteran at shift change. The RN assessed the right leg, noted no pulses, skin color changes, and contacted the on-call provider to evaluate the veteran. The medical provider on duty went to the veteran's bedside, noted absent pulses, and arranged transfer of the veteran to a non-VA hospital that could provide a higher level of care and an evaluation by a vascular surgeon.

Nursing Care. The veteran reported getting out of bed after admission to the medical unit to use the restroom on at least two occasions without using the call light to request assistance and soiling the bed, floor, and bathroom with feces. The veteran stated that the nasal cannula tubing supplying oxygen fell in the feces but was reused after the patient washed it off in the sink and that staff did not assist the veteran nor clean the bathroom after the incidents. The veteran and spouse were also upset that the staff continued to tell the veteran to use the call light to alert staff when needing assistance.

Review of the EHR showed that the veteran had two episodes of diarrhea during the admission and received an anti-diarrheal medication. An RN documented the veteran had a bed alarm that sounded three times during admission and the veteran had a bedside commode. The RN also documented incontinence care for the veteran and included a remark that it was helpful to have the spouse present since the veteran was not using the call light system.

We interviewed various nursing staff to determine the interventions implemented for patients at high risk for falls, with incontinence, with diarrhea, or who do not use the call light system. All staff responded they would place the patient in a room near the nurse's station, place the patient's bed in a low position, activate the bed alarm, and provide the patient a bedside commode. The identified interventions stated were consistent with documentation in the veteran's EHR.

The EHR review indicated appropriate triage and care for the symptoms the veteran was experiencing.

Issue 4: Podiatry Care Options

We did not substantiate the allegation that VA did not make the veteran aware of all alternatives to care related to podiatry concerns. The system podiatrists provided care from 2005 through 2009 and offered molded shoes, padding for toes, and toe callus removal, along with education for foot care. We found no indication or discussion of a need for surgical intervention in the EHR.

In 2013, a podiatry consult was submitted and the veteran was referred to a non-VA provider due to the inability of the system to provide timely care. Two non-VA podiatry providers evaluated the veteran in July 2013. The first provider offered the patient surgical options; however, the patient requested to see a second provider who advised the patient against surgery because of the risk.

Issue 5: Denial of Care

We did not substantiate the allegation that the system denied the spouse care under CHAMPVA. We reviewed the spouse's EHR and the relevant system policies.

Documented in the spouse's EHR was a request for a podiatry referral at the Fort Meade division, but the Fort Meade podiatry clinic had a long wait time for appointments. At the time, the spouse reported a desire to seek care in the private sector using CHAMPVA insurance. One month later, the spouse requested a podiatry referral at the Hot Springs division because of available appointments at this location. The spouse later cancelled the Hot Springs division podiatry appointment and attempted to obtain a referral to a private podiatrist. The triage RN documented in the EHR that the spouse was informed VA does not provide private podiatry service referrals for CHAMPVA and the system would not be responsible for the CHAMPVA care costs. The spouse indicated understanding as documented in the EHR. When interviewed, the spouse said a prescription written by a private podiatrist was faxed to the system; however, VHA is not responsible for the cost of CHAMPVA care received in the private sector and therefore would not fill these prescriptions.

Conclusions

We were unable to substantiate the allegation that the telephone contact and triage process in place during the timeframe of the complaint was cumbersome or resulted in delayed responses from the PCP to the patient calling for medical care or advice. The call center was initiated in 2010. The same system is still in place and instructs callers to use 911 in emergencies. The PACTs provide cards to the patients that include the direct telephone extension of the PACT RN and Licensed Practical Nurse, and telephone numbers for the system and after hours call center RN.

We did not substantiate the allegation that the spouse received false information on obtaining emergency care outside of the VA system. System staff instructed the spouse to bring the veteran to the Hot Springs division for evaluation. We found this to be the appropriate response to the urgent medical conditions the veteran's spouse described that the veteran was experiencing, as the Hot Springs division was the closest location and able to treat the conditions.

We did not substantiate the allegation that the veteran experienced "negligence and medical errors" at the system. We found that the veteran received appropriate medical and nursing care for the symptoms and issues as they were experienced and reported to medical or nursing staff.

We did not substantiate the allegation that VA did not make the veteran aware of all alternatives to care related to podiatry concerns. The system podiatrists provided care from 2005 through 2009 and there is no indication or discussion of a need for surgical options in the EHR. When the veteran was referred to podiatry services again in July 2013, the veteran was seen by non-VA care providers under a new consult.

We did not substantiate the allegation that the spouse was denied care under CHAMPVA through the system's pharmacy service. The system is not responsible for care provided in the private sector through CHAMPVA or the prescriptions related to that care.

We made no recommendations.

Appendix A

Acting VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: August 1, 2014

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

Subject: **Draft Report—Healthcare Inspection— Coordination and Delivery of Medical Care Concerns, VA Black Hills Health Care System, Fort Meade, South Dakota**

To: Director, Dallas Regional Office of Healthcare Inspections (54DA)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

Thank you for your inspection of the VA Black Hills Health Care System in response to the allegations made and the opportunity to review your findings and conclusions. I concur with the report.

Steven C. Julius, M.D.
Acting Director, VA Midwest Health Care Network (10N23)

Appendix B

System Director Comments

Department of Veterans Affairs

Memorandum

Date: August 1, 2014

From: Director, VA Black Hills Health Care System (568/00)

Subject: **Draft Report—Healthcare Inspection— Coordination and Delivery of Medical Care Concerns, VA Black Hills Health Care System, Fort Meade, South Dakota**

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

1. The VA Black Hills Health Care System concurs with the report – Healthcare Inspection – Coordination and Delivery of Medical Care Concerns, VA Black Hills Health Care System, Fort, Meade, South Dakota.

2. If you have any questions, you may contact the Director at VA Black Hills Health Care System at (605) 347-2511 Extension 7170.

Original signed by:

Stephen R. DiStasio, FACHE
Director, VA Black Hills Health Care System (568/00)

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Trina Rollins, MS, PA-C, Team Leader Gayle Karamanos, MS, PA-C Cathleen King, MHA, CRRN Misti Kincaid, BS Alan Mallinger, MD

Appendix D

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Midwest Health Care Network (10N23)
Director, VA Black Hills Health Care System (568/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: John Barrasso, Michael B. Enzi, Deb Fischer, Mike Johanns, Tim Johnson, John Thune
U.S. House of Representatives: Cynthia M. Lummis, Kristi Noem, Adrian Smith

This report is available on our web site at www.va.gov/oig.