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Office of Healthcare Inspections

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Healthcare Inspection
Inconsistent Transfer Procedures for Urgent Care Clinic Patients with Stroke Symptoms
Manchester VA Medical Center
Manchester, New Hampshire

September 7, 2017

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General conducted a healthcare inspection to evaluate stroke care at the Manchester VA Medical Center (facility), Manchester, NH, pursuant to an April 2015 request of Congresswoman Ann McLane Kuster, Ranking Minority Member of the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs. The Congresswoman's request was specifically in response to a Federal court ruling that the facility failed to adequately diagnose and treat a patient when he presented to the Urgent Care Clinic (UCC) with a stroke in 2010. The purpose of the review was to determine whether system issues may have led to poor care of the patient and to evaluate changes that the facility may have made in response to this incident.

We reviewed the UCC provider's patient assessment and the transfer processes that were in effect when the patient presented to the UCC. We found that, once the UCC provider identified that the patient's symptoms indicated a stroke, the patient should have been transferred to another facility with the capability to perform a complete diagnostic workup and care for stroke patients and should not have received any diagnostic evaluations at the facility.

In 2012, upon notification that a tort claim had been filed on behalf of the patient, facility managers conducted five internal peer reviews on the providers involved in the patient's care to determine if system changes could be implemented to prevent similar incidents in the future. We found that facility managers did not complete the peer review process as required by Veterans Health Administration (VHA).

To determine compliance with VHA and facility policy, we reviewed the electronic health records of 23 patients who presented to the facility UCC with one or more stroke symptoms and received a stroke related diagnosis (presumptive stroke) between June 2014 and May 2015. The review was based on current VHA and facility policy and processes including the facility process of promptly transferring patients after identifying stroke symptoms (without conducting diagnostic testing) to a community hospital with the capability to care for stroke patients. Contrary to VHA and facility policy and processes, UCC providers were inconsistent in their management of the patients reviewed. We found that UCC providers did not always transfer patients prior to conducting a diagnostic test. Additionally, when UCC providers transferred patients to an acute care facility as required by VHA policy, they did not consistently observe facility managers' expectations to transfer patients to a non-VA acute care hospital, approximately 2.5 miles away (closest acute care hospital). In addition, UCC providers did not always designate the patient's primary care provider as a co-signer after the patient's visit to the UCC as required by facility policy.

In mid-2015, facility managers initiated and completed a comprehensive internal review. During our follow-up visit in February 2016, facility managers described to us changes made in the UCC. Facility managers implemented provider and patient education and written guidance, and electronic health record application enhancements to improve the management of UCC patients with stroke symptoms.

We recommended that the Facility Director ensure that:

- UCC providers consistently transfer stroke patients to an appropriate acute care facility in accordance with VHA and facility policies and procedures.
- The Peer Review Committee follows VHA policy.
- Facility managers clinically review the records of the 13 patients not transferred to the non-VA acute care hospital, approximately 2.5 miles away, to determine whether patient harm occurred and take action, as appropriate.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes A and B, pages 12–15 for the Directors' comments.) Based on information received in July 2017, we consider Recommendations 2 and 3 closed. We will follow up on the planned actions for the remaining open recommendation until they are completed.

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

Purpose

The VA Office of Inspector General conducted a healthcare inspection to evaluate stroke care at the Manchester VA Medical Center (facility), Manchester, NH, pursuant to an April 2015 request of Congresswoman Ann McLane Kuster, Ranking Minority Member of the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs. The Congresswoman's request was specifically in response to a Federal court ruling that the facility failed to adequately diagnose and treat a patient when he presented to the Urgent Care Clinic (UCC) with a stroke in 2010. The purpose of the review was to determine whether system issues may have led to poor care of the patient and to evaluate changes that the facility may have made in response to this incident.

Background

The facility is located in Manchester, NH, and is part of Veterans Integrated Service Network (VISN) 1. The facility provides outpatient services in primary care, specialty care, and mental health, and operates a 112-bed community living center. The facility does not provide acute[1] inpatient care. Acute inpatient care is provided primarily through a contract arrangement with a non-VA acute care hospital approximately 17 miles away. A non-VA acute care hospital, approximately 2.5 miles away (closest acute care hospital), is available for patients with presumptive stroke symptoms[2] and possible time-critical needs. A tertiary VA medical center is approximately 66 miles away.

The facility UCC operates 24 hours a day, 7 days a week, and provides non-emergency care to patients without scheduled appointments whose conditions may require higher levels of care than is available in primary care settings. UCCs do not provide the full spectrum of emergency medical care.[3] When patients present to the UCC with care needs that exceed UCC capabilities, providers must make prompt efforts to transfer patients to a higher level of care.[4] Until April 2007, the facility operated an Emergency Department (ED);

[1] Meanings of acute in this context include: (a) providing short-term medical care for serious illness or traumatic injury, (b) having the characterization of sharpness or severity such as acute pain, (c) having a sudden onset, sharp rise, and short course such as acute disease.

[2] Within the context of this report, we considered a patient with presumptive stroke to have one or more stroke symptoms and/or had a stroke related diagnosis such as unspecified transient cerebral ischemia, subdural hemorrhage following injury without mention of open intracranial wound with state of consciousness, cerebral embolism with cerebral infarction, disturbance of skin sensation, cerebral artery occlusion unspecified with cerebral infarction, acute but ill-defined cerebrovascular disease, unspecified hemiplegia and hemiparesis affecting unspecified side, facial weakness, and altered mental status. Patients with presumptive stroke symptoms require a higher level of care than what could be provided in an UCC without diagnostic and therapeutic capabilities.

[3] VHA Directive 2010-010, *Standards for Emergency Department and Urgent Care Clinic Staffing Needs in VHA Facilities*, March 2, 2010. This Directive was rescinded and replaced by VHA Directive 1101.05(2), Emergency Medicine, September 2, 2016, amended October 27, 2016, and March 7, 2017, which contained similar language regarding the emergency medical care provided in the UCC.

[4] VHA Directive 2007-043, *Standards for Nomenclature and Operations for Urgent Care Clinics in VHA Facilities*, December 18, 2007. This Directive was rescinded and replaced in 2014 by VHA Directive 1079, *Standards for Nomenclature and Operations for Urgent Care Clinics in VA Medical Facilities*, February 3, 2014, which contained the same or similar language regarding the transfer of UCC patients.

however, it transitioned to a UCC designation after Veterans Health Administration (VHA) Directive 2006-051, *Standards for Nomenclature and Operations in VHA Emergency Departments,* was issued. The 2006 Directive required EDs to provide services consistent with the capabilities of the parent facility and ensure that EDs, at all times, have the appropriate equipment, trained staff to manage acute emergencies, and level of support services needed such as acute care inpatient beds.

As a result of the conversion of the ED to a UCC in 2007, facility providers' responsibilities for caring for stroke patients changed from delivering emergent care (which included diagnostic workup/testing and treatment) to urgent care (limited to the identification of stroke symptoms and arrangement for immediate transfer of the patient to an acute care facility with the capability to treat acute strokes).

Stroke Overview

A stroke occurs when the blood supply to the brain is interrupted, causing brain cells to die. Symptoms of acute stroke include new onset of leg, arm, or facial numbness or weakness; confusion or trouble understanding; trouble seeing in one or both eyes; trouble walking; dizziness; loss of balance or coordination; and severe headache.[5] Annually, over 795,000 people suffer a stroke in the United States. It is the fifth leading cause of death and a major cause of disability.[6]

Neurologists generally divide strokes into two types: ischemic and hemorrhagic. About 85 percent of strokes are acute ischemic strokes, where a blockage of an artery or arteries supplying blood and oxygen to the brain cuts off the blood supply to the brain.[7] Typically, a blood clot occurring in a brain vessel causes the blockage, with the clot severely reducing or preventing blood flow to tissue beyond it.[8] One of the dangers of this type of stroke is when symptoms gradually occur over several hours or days. This extension is an evolving stroke or stroke-in-evolution, and may be difficult to identify.[9]

In contrast, acute hemorrhagic strokes result from a weakened vessel that ruptures and bleeds into the surrounding brain compressing the brain tissue.[10] Hypertension frequently

[5] Mayo Clinic Stroke: Symptoms and causes. http://www.mayoclinic.org/diseases-conditions/stroke/symptoms-causes/ hemorrhage dxc-20117265. Accessed June 28, 2016.
[6] Centers for Disease Control and Prevention Stroke Facts. http://www.cdc.gov/stroke/facts.htm. Accessed June 28, 2016.
[7] Mayo Clinic Stroke: Symptoms and causes. http://www.mayoclinic.org/diseases-conditions/stroke/symptoms-causes/dxc-20117265. Accessed June 28, 2016.
[8] Cedars-Sinai. Ischemic Stroke. http://www.cedars-sinai.edu/Patients/Health-Conditions/Ischemic-Stroke.aspx. Accessed June 28, 2016.
[9] Johns Hopkins Medicine, Types of Stroke, http://www.hopkinsmedicine.org/healthlibrary/conditions/nervous_system_disorders/types_of_stroke_85,P00813/ Accessed December 2, 2016.
[10] American Heart Association American Stroke Association. Types of Stroke. Hemorrhagic Bleeds. Accessed June 28, 2016.

causes acute hemorrhagic strokes and may be referred to as an intracerebral hemorrhage.[11]

To diagnose a stroke, physicians obtain the patient's medical history, conduct a physical and neurological examination, and order blood tests. If symptoms do not clearly identify a stroke diagnosis, physicians may order a diagnostic test, such as a computed tomography (CT) scan. Once a stroke is diagnosed, the physician may continue to order other diagnostic tests to identify the type as each type is treated differently.[12]

One of the greatest risks immediately after a completed stroke (stroke is not acute or evolving) is another stroke, or a recurrent stroke. Over time, this risk lessens; however, approximately 3 percent of stroke patients have a second stroke within 30 days of their first stroke, and approximately one-third have a second stroke within 2 years.[13]

Regardless of the type (ischemic or hemorrhagic) or extent (acute, evolving, or complete), a stroke has important treatment and prognostic implications.[14]

VHA Initiative on Stroke Care

As part of a collaboration between neurology and emergency medicine specialty care services, the Office of Rural Health, and the Office of Connected Care, VHA developed a national tele-stroke program. The program will provide around the clock neurology consultation and guidance to providers for acute stroke management, linking VA medical centers with restricted neurology coverage to a network of stroke specialists via clinical video telehealth. In March 2016, VHA officials informed us that the program will be implemented over the next 5 years, beginning with rural sites and locations with the greatest challenges recruiting and retaining neurology staff, and then to other VA facilities.

Facility UCC Management of Patients Presenting With Stroke Symptoms

Stroke Workup and Transfers. In 2011, VHA issued a directive requiring all medical facilities with inpatient acute care medical or surgical beds to be assessed for capability and assigned an appropriate designation for stroke care.[15] The facility did not (and currently does not) have inpatient medical or surgical beds. Without the capability to care for stroke patients, the facility did not meet the criteria for designation as a stroke care

[11] Cedars-Sinai. Stroke. https://www.cedars-sinai.edu/Patients/Health-Conditions/Stroke.aspx. Accessed August 31, 2016.
[12] American Heart Association American Stroke Association http://www.strokeassociation.org/STROKEORG/AboutStroke/Treatment/Diagnosis/Stroke-Diagnosis_UCM_310890_Article.jsp. Accessed December 21, 2016.
[13] Johns Hopkins Medicine, Types of Stroke, http://www.hopkinsmedicine.org/healthlibrary/conditions/nervous_system_disorders/types_of_stroke_85,P00813/ Accessed on December 2, 2016.
[14] National Stroke Association. Stroke Treatments. http://www.stroke.org/we-can-help/survivors/just-experienced-stroke/stroke-treatments. Accessed August 31, 2016.
[15] VHA Directive 2011-038, *Treatment of Acute Ischemic Stroke*, November 2, 2011. This Directive expired November 30, 2016 and has not yet been replaced. This Directive was not in effect at the time that the subject patient received care in the UCC. We reviewed the Directive to assess more current circumstances and practice.

facility. According to the 2011 Directive, "Guidelines for the management of AIS [acute ischemic stroke] must be posted in the ED, the UCC, and at the nursing stations on the units in all VHA facilities."[16] VHA Directive 1079, *Standards for Nomenclature and Operations for Urgent Care Clinics in VA Medical Facilities*, February 3, 2014, specified that when patient care needs exceed UCC level of care "the facility must provide initial stabilization and arrange for emergency transfer or transportation to an appropriate higher-level facility."[17] [18] [19]

According to a policy statement from the American Heart Association and the American Stroke Association, when several hospitals are available to receive a stroke patient, the patient should be transferred to the nearest hospital capable of providing the highest level of stroke care.[20] "All efforts must be made to avoid unnecessary delays during patient transport."[21]

The facility expectations for providers were to send patients to the closest acute care hospital when patients presented to the UCC with presumptive stroke symptoms and possible time-critical needs.

Provider Communication. To ensure continuity of care upon discharge or transfer of stroke patients and to enhance provider-to provider communication, a 2012 facility policy required that the UCC provider designate the patient's primary care provider (PCP) as a cosigner of the discharge note.[22] In July 2014, The Joint Commission recognized that high-quality care transfers from UCCs require timely, accurate, and consistent provider-to-provider communication of clinical information.[23]

[16] VHA Directive 2011-038, *Treatment of Acute Ischemic Stroke*, November 2, 2011. This Directive was issued in 2011 and was not in effect at the time that the patient received care in the UCC. We reviewed the Directive to assess more current circumstances and practice.
[17] At the facility, standard operating procedures for transfer were undocumented until January 2016, when an algorithm was produced and implemented for UCC providers, stemming from an unrelated, internal review.
[18] VHA Directive 1079, *Standards for Nomenclature and Operations for Urgent Care Clinics in VA Medical Facilities*, February 3, 2014. This Directive was not in effect at the time that the patient received care in the UCC. We reviewed the Directive to assess more current circumstances and practice.
[19] VHA Directive 2011-038, *Treatment of Acute Ischemic Stroke*, November 2, 2011. This Directive was issued in 2011 and was not in effect at the time that the patient received care in the UCC. We reviewed the Directive to assess more current circumstances and practice.
[20] American Heart Association. Stroke. AHA/ASA Policy Statement - Interactions Within Stroke Systems of Care. 2013; 44: 2961-2984. Published online before print August 29, 2013, doi: 10.1161/STR.0b013e3182a6d2b2 http://stroke.ahajournals.org/content/44/10/2961.full Accessed September 1, 2016.
[21] American Heart Association. Guidelines for the Early Management of Patients with Acute Ischemic Stroke. January 31, 2013. http://stroke.ahajournals.org/content/early/2013/01/31/STR.0b013e318284056a.full
[22] Manchester VA Medical Center Policy 11-44, *The Care of Patients Presenting to Urgent Care*, June 2012.
[23] Shamji H, Baier R, Gravenstein Stefan, Gardner R L. Improving the Quality of Care and Communication During Patient Transitions: Best Practices for Urgent Care Centers. *The Joint Commission Journal on Quality and Patient Safety*. July 2014; Vol. 40, No. 319:324.

Overview of Court Ruling[24]

On April 3, 2015, the U.S. District Court of New Hampshire ruled that the facility failed to adequately diagnose and treat a patient when he presented to the UCC with an ischemic stroke on October 21, 2010. The patient suffered a second stroke a few weeks later leaving the patient severely disabled.

Congressional Request

In late April 2015, Congresswoman Kuster sent a letter to the former Acting Inspector General requesting OIG investigate the circumstances surrounding a patient's treatment. On May 15, 2015, the Acting Inspector General informed Congresswoman Kuster that OIG would conduct a review to determine whether system issues may have led to poor care of the patient and to evaluate changes that the facility may have made in response to this incident.

Scope and Methodology

We initiated our inspection in April 2015. We evaluated (a) the circumstances surrounding the patient's care in October 2010, (b) the extent to which system issues at the facility may have contributed to the patient's poor care, and (c) what changes the facility may have made in response to this patient incident.

We conducted an initial site visit on June 3–4, 2015, and a follow-up site visit on February 10, 2016. During the initial site visit, we conducted an unannounced physical inspection of the UCC. We interviewed the former and current Facility Directors, the Chief of Staff, the UCC Director, the Associate Chief of Clinical Pharmacy, the Patient Safety Manager, the former Risk and Quality Manager,[25] the current Quality Manager, the Clinical Applications Coordinator, UCC providers, clinical engineering staff, and other staff with knowledge relating to the patient and his treatment. We also spoke with VHA's National Stroke Program staff. We were unable to interview the UCC provider or the PCP who treated the patient because they were no longer employed by VA.

We reviewed the electronic health records (EHRs) of 23 presumptive stroke patients[26] between June 2014 and May 2015.

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[24] *Jeanice Farley, Individually and on Behalf of Michael Farley, an Incompetent Adult* v. *United States of America. 2015 DNH 064. U.S District Court of New Hampshire. 3 Apr. 2015. N.p., n.d. Web. 16 April. 2015.* <http://www.nhd.uscourts.gov/sites/default/files/opinions/15/15NH064.pdf>.

[25] The former Quality Manager was also the Quality Risk Manager at the facility.

[26] We initially reviewed the EHRs of 68 patients who presented to the UCC with one or more stroke symptoms between June 2014 and May 2015. Because one or more stroke symptoms could indicate medical conditions other than stroke, we selected 23 of the 68 patients who had one or more stroke symptoms and had a stroke related diagnosis (presumptive stroke patients), such as unspecified transient cerebral ischemia, subdural hemorrhage following injury without mention of open intracranial wound with state of consciousness, cerebral embolism with cerebral infarction, disturbance of skin sensation, cerebral artery occlusion unspecified with cerebral infarction, acute but ill-defined cerebrovascular disease, unspecified hemiplegia and hemiparesis affecting unspecified side, facial weakness, and altered mental status.

We reviewed VHA and facility policies and procedures, The Joint Commission guidelines, quality and performance improvement data and documents, and credentialing and privileging records of the patient's UCC provider, and other relevant documents.[27]

Three policies cited in this report were expired or beyond the recertification date:

1. VHA Directive 2011-038, *Treatment of Acute Ischemic Stroke*, November 2, 2011 (expired November 30, 2016).
2. VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 (expired June 30, 2015).
3. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011 (recertification due date March 31, 2016).

We considered these policies to be in effect as they had not been superseded by more recent policy or guidance. In a June 29, 2016 memorandum to supplement policy provided by VHA Directive 6330(1),[28] the VA Under Secretary for Health (USH) mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[29] The USH also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[30]

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts show the allegations are unfounded. We **cannot substantiate** allegations when there is no conclusive evidence to either sustain or refute the allegation

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

In 2010, a patient in his 50s with a medical history of hypertension and hyperlipidemia called the facility with complaints of blurred vision for 2 days and partial loss of vision in his right eye. A triage registered nurse (RN) discussed the case with a facility optometrist, who recommended that the patient come into the Eye Clinic for evaluation.

The patient was unable to come into the facility on that day, but presented to the UCC for evaluation the next day complaining of recent visual changes and a left-sided headache,

[27] VHA Directive 2011-038, *Treatment of Acute Ischemic Stroke (AIS)*, November 2, 2011. This Directive was issued in 2011 and was not in effect at the time that the patient received care in the UCC. We reviewed the Directive to assess whether facility clinicians and managers were currently in compliance.
[28] VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended on January 11, 2017.
[29] VA Under Secretary for Health Memorandum. *Validity of VHA Policy Document*, June 29, 2016.
[30] Ibid.

which became worse when he coughed. He told the UCC staff that pain medications had not helped the headache. According to the UCC provider's assessment, the patient had no hand weakness, a normal walking gait, and clear speech. The UCC provider ordered STAT[31] blood tests, and a STAT brain CT[32] imaging study.

The blood tests had no significant chemistry findings, and the CT scan of the brain showed a subacute[33] stroke but no intracranial hemorrhage or masses. The UCC provider ordered a CT angiogram (CTA)[34] that showed that the arteries supplying blood to the head and neck were normal in appearance with a small amount of plaque in a portion of one of the major arteries.

The UCC provider also ordered an electrocardiogram to be done while the patient was in the UCC and a transesophageal echocardiogram (TEE)[35] for a later date. The electrocardiogram was normal. The UCC provider discharged the patient with instructions to take two baby aspirin that day and then every morning, and to return for new or any worsening symptoms.

Four days after the UCC visit, the UCC provider cancelled the TEE. Approximately 3 weeks later, a facility cardiologist performed a transthoracic echocardiogram[36] (TTE) with a bubble study on the patient.[37,38] The TTE report showed abnormalities of the coronary arteries and functioning of the heart.

Twelve days later, the patient presented for a scheduled PCP appointment. The PCP evaluated the patient and documented that he had a discussion with the patient regarding the TTE findings. The PCP's documentation did not reference the patient's recent CT results, which indicated a subacute stroke.

Two days after the PCP visit, a friend of the patient notified the facility that the patient was hospitalized at the non-VA acute care hospital, approximately 2.5 miles away (closest acute care hospital), after suffering an acute stroke that had left the patient severely disabled.

[31] STAT, from the Latin statim, means immediately, without delay, Merriam-Webster Dictionary, http://www.merriam-webster.com/dictionary/stat. Accessed February 12, 2016.
[32] CT is a diagnostic imaging test used to create three-dimensional images of internal organs, bones, soft tissue, and blood vessels, and no contrast dye or material is used.
[33] Subacute refers to an event with a recent onset or somewhat rapid change in contrast to an acute event with a very sudden onset and rapid change or a chronic event, which indicates indefinite duration or virtually no changes.
[34] CTA combines the injection of a contrast material with CT to diagnose blood vessel disease or related conditions.
[35] A TEE is an invasive procedure to take clear pictures of the heart structures and valves by attaching a transducer that produces sound waves to a thin tube, which is then passed through the mouth, down the throat, and into the esophagus.
[36] The TTE is a non-invasive procedure, using a transducer probe placed upon the chest to capture pictures of the heart.
[37] An echocardiogram with a bubble study helps to obtain better pictures by using sterile salt water (saline) as a contrast; the saline is shaken to create bubbles and injected into the vein through an intravenous line that allows improved imaging of the blood as it flows through the heart.
[38] De Bruijn S, Agema, W R P, Lammers, G J, et al. Transesophageal Echocardiography is Superior to Transthoracic Echocardiography in Management of Patients of Any Age with Transient Ischemic Attack or Stroke. *Stroke* 2006; 37:2531-2534.

Inspection Results

Issue 1: Facility System Issues That May Have Led to the Patient's Poor Care

We reviewed the UCC provider's patient assessment and the transfer processes that were in effect when the patient presented to the UCC. We found that, once the UCC provider identified the presence of a subacute stroke on the CT scan, the patient should have been transferred to another facility with the capability to perform a complete diagnostic workup and care for stroke patients, and should not have received further diagnostic evaluations at the facility. Facility managers were notified of the pending court case in 2012 and conducted five internal peer reviews. We identified a deficiency in the Peer Review process.

According to the UCC provider's medical supervisor during the time of the patient's care, UCC providers should not conduct diagnostic workups to determine the extent (acute, evolving, or complete) or type (ischemic or hemorrhagic) of stroke; rather, UCC providers should transfer patients to a facility that can provide the level of care required. This transfer process was in accordance with VHA's requirement that providers make prompt efforts to transfer patients to a higher level of care when patients present to the UCC with care needs that exceed UCC capabilities.[39]

When the patient first presented to the UCC provider, the provider did not know whether the patient's symptoms were indicative of a stroke or another medical issue. In the absence of clear stroke symptoms and as the next step to identify the patient's underlying condition, the provider ordered a CT scan that indicated a subacute stroke. However, after reviewing the results of the CT scan, the provider, rather than transferring the patient to a facility with the appropriate level of care, ordered additional diagnostic tests.

In two June 2015 interviews, one UCC provider reported that facility UCC providers continued to manage patients, whose symptoms indicated a stroke, as they had when the facility had an ED and did not begin to follow procedure to promptly transfer the patients to a higher level of care until 2009/2010. A second UCC provider corroborated this account but believed the practice continued until mid-2013.

[39] VHA Directive 2007-043, *Standards for Nomenclature and Operations for Urgent Care Clinics in VHA Facilities*, December 18, 2007. This Directive was rescinded and replaced in 2014 by VHA Directive 1079, *Standards for Nomenclature and Operations for Urgent Care Clinics in VA Medical Facilities*, February 3, 2014, which contained the same or similar language regarding the transfer of UCC patients.

Upon notification, in 2012, that a tort claim had been filed on behalf of the patient, facility managers initiated five internal peer reviews [40] on the providers involved in the patient's care, in accordance with VHA policy.[41]

The Peer Review Committee is responsible for ensuring that meeting minutes include formal committee discussions regarding a peer review or system issues as well as resolution of any actions taken by the committee or a provider's supervisor.[42] We identified a deficiency in the Peer Review process. Further discussion of the results of the review is prohibited as the content of Peer Reviews is protected under 38 U.S.C. 5705.[43]

Issue 2: Facility Policy/Process Changes

Facility UCC Stroke Management Issues Identified Through OIG EHR Reviews. To determine compliance with VHA and facility policy, we reviewed the EHRs of 23 presumptive stroke patients with possible time-critical needs between June 2014 and May 2015. We found system issues related to stroke workups including diagnostic evaluations, patient transfers to acute care facilities when UCC providers identified stroke symptoms, and communication between UCC providers and patients' PCPs.

We reviewed the EHRs of the identified patients to determine if they were transferred to the appropriate higher level of care considering the patients' symptoms and the providers' assessments. Based on current VHA policy and facility processes, we used four specific review questions to determine whether UCC providers followed the VHA and facility policies and processes.

Did UCC providers:

- Initiate stroke workups;
- Perform diagnostic evaluations and if so, the extent of those evaluations;
- Transfer patients to acute care hospitals, and
- Designate the patient's PCP as a co-signer in the EHR upon discharge from the UCC?

After review of the EHRs, we identified the following system issues related to stroke workups including diagnostic evaluations, patient transfers to acute care hospitals when

[40] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010. This Directive expired June 30, 2015 and has not yet been replaced. Peer review is a systematic, confidential, and non-punitive process to evaluate the care delivered by providers to improve the quality of health care and the utilization of resources. Peer review may also identify system issues that may have contributed to or caused a failure in the care of a patient, and are discussed by a committee which determines whether the patient's care was poor and whether corrective actions should be taken.
[41] Ibid.
[42] Ibid.
[43] Ibid, p. 1. "VHA peer review activities, in compliance with this Directive and current VHA policy, meet the requirements for a quality management document to be confidential and protected by 38 U.S.C. 5705."

UCC providers identified stroke symptoms, and communication between UCC providers and the patient's PCP. UCC providers:

- Did not promptly transfer presumptive stroke patients to an acute care hospital; rather, they started a diagnostic evaluation (CT scan) for 6 of the 23 patients (26 percent).
- Did not transfer 2 of the 23 patients (9 percent) to an acute care hospital.[44]
- Did not utilize the non-VA acute care hospital, approximately 2.5 miles away (closest acute care hospital), for 11 of the remaining 21 patients (52 percent) sent to acute care hospitals.
- Did not designate the patient's PCP as a cosigner on the UCC discharge note for 4 of the 23 patients (17 percent).

System Issues Identified Through Comprehensive Internal Review in 2015. According to VHA policy, internal reviews are necessary to identify and explore system vulnerabilities that can result in patient harm. These internal reviews can be of a single patient incident or aggregated risk data.[45]

Prior to learning about the court's ruling, facility managers had not initiated a comprehensive internal review of the patient's care or associated risks for other presumptive stroke patients. However, at the conclusion of our initial site visit, facility managers initiated a comprehensive internal review.

During our follow-up site visit on February 10, 2016, facility managers described to us changes they had instituted:

- In August 2015,
    - Reminded UCC providers that a patient's PCP must be added as an additional cosigner for all UCC visits. Facility Managers added a tracker to the Medical Record Committee review tool as a monitor to measure compliance.
    - Ensured that UCC providers completed stroke management training.
- In September 2015,
    - Implemented enhanced EHR applications to improve the management of UCC patients with stroke symptoms.
    - Revised the algorithm for UCC providers to illustrate patient flow and identify the appropriate party to call for emergency ambulance transportation.
    - Trained UCC providers on culture and functionality differences between EDs and UCCs.

[44] Of the two patients, one returned to the facility community living center and one patient was discharged to home.
[45] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. This Handbook was scheduled for recertification on or before the last working day of March 2016 but has not yet been recertified.

- In October 2015, provided patients a handout, *Non-VA Emergency Care Fact Sheet*, with information on when to seek care at an ED rather than the facility UCC.

Conclusions

We reviewed the UCC provider's patient assessment and the transfer processes that were in effect when the patient presented to the UCC. We found that, once the UCC provider identified that the patient's symptoms indicated a stroke, the patient should have been transferred to another facility with the capability to perform a complete diagnostic workup and care for stroke patients, and should not have received further diagnostic tests at the facility.

Upon notification, in 2012, that a tort claim had been filed on behalf of the patient, facility managers conducted five internal peer reviews on the providers involved in the patient's care, we found that facility managers did not complete the peer review process as required by VHA policy.

We reviewed the EHRs of 23 presumptive stroke patients between June 2014 and May 2015. Facility expectations were to send such patients to the non-VA acute care hospital, approximately 2.5 miles away (closest acute care hospital). UCC providers were inconsistent in their management of the patients reviewed and did not always transfer patients, prior to conducting a diagnostic test, to the closest acute care hospital. In addition, UCC providers did not always designate the patient's PCP as a cosigner upon the patient's discharge from the UCC as required by facility policy.

In mid-2015, facility managers initiated and completed a comprehensive internal review. During our follow-up visit in February 2016, facility managers described to us changes made in the UCC. Facility managers implemented provider and patient education and written guidance, and EHR application enhancements to improve the management of UCC patients with stroke symptoms.

Recommendations

1. We recommended that the Facility Director ensure that Urgent Care Clinic providers consistently transfer stroke patients to an appropriate acute care facility in accordance with Veterans Health Administration and facility policies and procedures.

2. We recommended that the Facility Director ensure that the Peer Review Committee follows Veterans Health Administration policy.

3. We recommended that the Facility Director ensure that facility managers clinically review the records of the 13 patients not transferred to the non-VA acute care hospital, approximately 2.5 miles away, to determine whether patient harm occurred and take action as appropriate.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: July 11, 2017

From: Director, VA New England Healthcare System (10N1)

Subj: Healthcare Inspection—Inconsistent Transfer Procedures for Urgent Care Clinic Patients with Stroke Symptoms, Manchester VA Medical Center, Manchester, New Hampshire

To: Director, Bedford Office of Healthcare Inspections (54BN)
Director, Management Review Service (VHA 10E1D MRS Action)

1. The VA New England Healthcare System has reviewed and concurred with the findings, recommendations and corrective actions included in the draft report submitted by the Manchester VA Medical Center, Manchester, New Hampshire.

2. If you have questions regarding the information submitted, please contact Janice Bernzott, VISN 1 Quality Management Officer, at 781-687-4979.

(*original signed by* Barrett Franklin, Deputy Network Director, *for:)*
Michael F. Mayo-Smith, MD, MPH
Network Director, VISN 1

Appendix B

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: July 11, 2017

From: Director, Manchester VA Medical Center (608/00)

Subj: Healthcare Inspection— Inconsistent Transfer Procedures for Urgent Care Clinic Patients with Stroke Symptoms, Manchester VA Medical Center, Manchester, New Hampshire

To: Director, VA New England Healthcare System (10N1)

1. Please see, below, the Manchester VA Medical Center's response to the recommendations made by OIG review conducted in April 2015 and completed in June 2016.

Danielle S. Ocker, BSN, MBA
Medical Center Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Facility Director ensure that Urgent Care Clinic providers consistently transfer stroke patients to an appropriate acute care facility in accordance with Veterans Health Administration and facility policies and procedures.

Concur

Target date for completion: October 31, 2017

Facility response: As noted in the OIG report, the facility had already initiated procedural changes in the Urgent Care Clinic to improve the management of patients with stroke-like symptoms. To ensure sustainment of these initiatives, the medical center will conduct a 100% audit of all patients with stroke-like presentation for the next 90 days, or until 90% or greater compliance. Because of the wealth of options, the facility will tailor the choice of receiving facility to the patient's needs and American Heart Association and the American Stroke Association guidelines, rather than opting for one specific facility for every patient.

Recommendation 2. We recommended that the Facility Director ensure that the Peer Review Committee follows Veterans Health Administration policy.

Concur

Target date for completion: May 31, 2017

Facility response: The facility is committed to performing timely and effective peer review activity as verified by auditing the three most recent signed Peer Review Committee minutes. The Peer Review Committee complies with VHA Directive 2010-025, but the minutes of the peer review committee meetings did not accurately reflect the robust discussions that took place regarding each peer review. The minutes template was revised to include the required elements. Three months of minutes for March, April, and May 2017 are included to support closure of the recommendation.

OIG Comment: Based on information received in July 2017, we consider this recommendation closed.

Recommendation 3. We recommended that the Facility Director ensure that facility managers clinically review the records of the 13 patients not transferred to the non-VA acute care hospital, approximately 2.5 miles away, to determine whether patient harm occurred and take action, as appropriate.

Concur

Target date for completion: July 10, 2017

Facility response: The facility has completed the review of the records of the 13 patients not transferred to the non-VA acute care hospital, approximately 2.5 miles away, to determine whether patient harm occurred. No clinical harm was identified as a result of using the Non-VA facilities greater than 2.5 miles. It was noted that all facilities in the review were within the American Heart Association and the American Stroke Association guidelines for timely response. In all reviewed cases of acute suspected stroke, patients were transferred to a facility within that radius, though not always the current facility of preference. This review determined that the actions taken were within the standard of care for patients with a potential diagnosis of stroke. The facility will tailor the choice of receiving facility to the patient's needs and American Heart Association and the American Stroke Association guidelines, rather than opting for a specific facility based on mileage.

OIG Comment: Based on information received in July 2017, we consider this recommendation closed.

Appendix C

OIG Contact and Staff Acknowledgements

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Clarissa Reynolds, CNHA, MBA, Team Leader Francis Keslof, EMT, MHA Thomas Wong, DO Elaine Kahigian, RN, JD Roneisha Charles, BS

Appendix D

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