DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Emergency Department Care of Intoxicated Patients and Those with Mental Health Conditions at the Louis Stokes Cleveland VA Medical Center

Ohio

HEALTHCARE INSPECTION | REPORT #19-07818-242 | SEPTEMBER 27, 2019

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Executive Summary

The VA Office of Inspector General (OIG) conducted a rapid response healthcare inspection to evaluate allegations from a confidential complainant that some intoxicated patients or those presenting with mental health-related issues to the Louis Stokes Cleveland VA Medical Center (facility) Emergency Department were not adequately assessed prior to transfer to the facility's Psychiatric Assessment and Observation Center (PAOC), thus placing patients with medical conditions at risk.[1] The Joint Commission and Veterans Health Administration's (VHA) Office of the Medical Inspector previously evaluated similar allegations, and the facility implemented corrective actions.[2] However, the complainant alleged that Emergency Department providers continued to

- Send patients to the PAOC without medical screening notes;
- Document that patients had no emergent medical issues, but this conclusion was not based on an assessment or the patient's most current laboratory values or diagnostic studies; and
- Send patients to the PAOC in active alcohol withdrawal, with blood alcohol levels over 300, and with critical laboratory values.[3] As a result, patients had to be sent directly from the PAOC to a medical unit for medical stabilization.

Prior to August 2018, when the facility had a Psychiatric Emergency Department (rather than a PAOC), facility policy did not require all intoxicated patients or those with primary mental health concerns to be medically screened in the Emergency Department triage area.[4] The OIG reviewed the 32 patient examples provided by the complainant and determined that in many cases, patients did not have a documented medical screening examination prior to transfer to the

[1] Patients are screened to obtain clinical information about stability for transfer to the PAOC. Patients with unstable and untreated medical conditions are at risk for adverse clinical outcomes.

[2] The Joint Commission, an independent organization that accredits and certifies health care organizations and programs in the United States, conducted an unannounced visit to the facility in July 2018. The Veterans Health Administration Office of the Medical Inspector independently investigates health care issues in an effort to monitor and improve the quality of care provided by VHA. The Office of the Medical Inspector conducted a site visit July 23-25, 2018. Both organizations identified environment of care and compliance with facility policy concerns.

[3] The concentration of alcohol in blood correlates directly with the degree of intoxication. The legal limit of intoxication is 80 milligram per deciliter (mg/dL). A concentration of 400 mg/dL or greater is potentially lethal.

[4] Facility Policy 116A-013, *Psychiatric Emergency Room/23 Hour Observation Unit*, January 12, 2015, only required walk-in patients to be screened in the Emergency Department triage area.

PAOC.[5] However, the OIG determined that the facility was compliant with the policy in effect at that time. Following visits from The Joint Commission and the Office of Medical Inspector in 2018, the facility changed its policy to require that all patients presenting with intoxication or an acute mental health condition be medically screened in the Emergency Department before transfer to the PAOC.

To determine if the facility was following the new policy, the OIG reviewed 205 encounters for patients seen in the Emergency Department and subsequently transferred to the PAOC, between January 1, 2019, and March 31, 2019. The OIG did not substantiate that patients were being transferred to the PAOC without medical screening examination notes. However, the OIG found that the electronic health record medical screening examination template did not require providers to document clinical information used to support their decisions about patient stability for transfer to the PAOC. In one case, an Emergency Department provider documented in the medical screening examination template, "[t]he patient does NOT have an emergency medical condition." Although the patient's history included recent use of drugs and alcohol, the Emergency Department provider did not document a sufficient history and physical examination or complete a medical workup to establish the patient's medical stability for transfer to the PAOC. The patient was subsequently transferred to the PAOC and found to have an abnormal creatine phosphokinase of 573 that required inpatient medical treatment.[6] While the patient ultimately received appropriate and timely care, the lack of an adequate Emergency Department screening had the potential to place the patient at risk for poor adverse clinical outcomes.[7] Additionally, the OIG noted that the Emergency Department physician documented the patient's medical stability after the patient was transferred to the PAOC. The OIG recognizes that it is possible that the Emergency Department physician entered the medical screening examination note late.

The OIG did not substantiate that patients were seen in the Emergency Department and subsequently transferred to the PAOC in active alcohol withdrawal. Of the 205 patient encounters reviewed by the OIG, none of the patients were transferred to the PAOC with a Clinical Institute Withdrawal Assessment for alcohol score higher than 8 (scores of less than 8

[5] The original allegation included 34 patient names; however, the OIG team was unable to find one patient based on the information provided, and another patient was not seen in the PAOC. Those two cases were excluded from further review.

[6] Creatine phosphokinase is an enzyme in the body, found mainly in the heart, brain, and skeletal muscle. Normal values are 10 to 120 micrograms per liter. High creatine phosphokinase values may be seen in people who have delirium tremens, heart attack, stroke, or rhabdomyolysis.

[7] For the purpose of this report, the OIG considered an adverse clinical outcome to be death, a change in the course of treatment or diagnosis, or significant change in the patient's level of care.

indicate minimal to mild withdrawal), and none of the patients with a recorded blood alcohol level were transferred to the PAOC with blood alcohol levels greater than 300.

The OIG did not substantiate that patients were transferred from the Emergency Department to the PAOC with critical laboratory values. Laboratory tests were ordered by the Emergency Department physician for 29 patients (of the 205 encounters the OIG reviewed). Four of the 29 patients had abnormal or critical laboratory results, with three patients treated by the Emergency Department physician. The fourth patient had an elevated blood glucose level that was acknowledged by the Emergency Department physician who documented that insulin would be provided in the PAOC. When the patient's blood glucose was retaken in the PAOC, it had decreased and insulin was not administered.[8]

The OIG found no evidence of adverse clinical outcomes related to the management of patients receiving care in the PAOC.

The OIG made one recommendation that the Facility Director defines what elements are required for a medical screening exam to deem a patient medically stable prior to transfer to the Psychiatric Assessment and Observation Center.

Comments

The Veterans Integrated Service Network Director and Facility Director concurred with the recommendation and provided an acceptable action plan (see appendixes A–B, pages 11–13). The OIG considers the recommendation open and will follow up on the planned action until it is completed.

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

[8] An elevated blood glucose level in a patient with diabetes may be treated in a variety of ways, including administration of insulin or with fluid hydration.

Contents

Abbreviations

CIWA	Clinical Institute Withdrawal Assessment
CPK	creatine phosphokinase
EHR	electronic health record
MSE	medical screening examination
OIG	Office of Inspector General
OMI	Office of Medical Inspector
PAOC	Psychiatric Assessment and Observation Center
TJC	The Joint Commission
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a rapid response inspection to evaluate allegations that some patients, presenting with alcohol intoxication and mental health-related issues to the Louis Stokes Cleveland VA Medical Center (facility) Emergency Department, were not adequately assessed prior to transfer to the facility's Psychiatric Assessment and Observation Center (PAOC), and that this practice placed patients at risk for adverse clinical outcomes.[9] The Joint Commission (TJC) and Veterans Health Administration's (VHA's) Office of the Medical Inspector (OMI) previously evaluated the allegations.[10] The purpose of the review was to assess the merit of the allegations.

Background

The facility, part of Veteran Integrated Service Network (VISN) 10, operates community based outpatient clinics in Akron, Canton, Calcutta, Cleveland, Willoughby, Sheffield Village, Mansfield, New Philadelphia, Parma, Ravenna, Sandusky, Warren, and Youngstown, Ohio. VA classifies the facility as Level 1a—High Complexity.[11] From October 1, 2017, through September 30, 2018, the facility served 111,234 patients and had a total of 674 hospital operating beds.[12]

Emergency Department Care for Intoxication and Mental Health Conditions

Medical problems are commonly present in Emergency Department patients who are intoxicated or present with mental health conditions.[13] In 2014, TJC identified the boarding of patients with primarily mental health conditions, including intoxication, in the Emergency Department as a

[9] For the purpose of this report, the OIG considered an adverse clinical outcome to be death, a change in the course of treatment or diagnosis, or significant change in the patient's level of care.
[10] The Joint Commission (TJC) is an independent healthcare accreditation organization. https://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx. (The website was accessed on June 11, 2019.) The VHA Office of Medical Inspector (OMI) independently investigates healthcare issues. https://www.va.gov/health/medicalinspector/. (The website was accessed on June 11, 2019.)
[11] The VHA Facility Complexity Model categorizes medical facilities based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3, with Level 1a facilities being the most complex and Level 3 facilities being the least complex.
[12] The bed count included 296 inpatient beds, 180 domiciliary beds, 173 community living center beds, and 25 Compensated Work Therapy Transitional Residence beds.
[13] Alcohol is responsible for up to one-third of drug-related Emergency Department visits. Alcohol-Related Visits to US Emergency Departments, 2001-2011. *Alcohol and Alcoholism,* 2017, 52(1) October 5, 2016.

persistent problem nationwide. Specifically, the lack of available mental health services and qualified professionals to treat these patients contributed to delays in mental health treatment, consumed Emergency Department resources, worsened Emergency Department overcrowding, and delayed treatment for patients who had non-mental health conditions. To provide care for patients exhibiting intoxication, suicidal ideation, or substance abuse issues, or who were a threat to Emergency Department staff or themselves, TJC recommended several options including the creation of dedicated psychiatric emergency services, such as a stand-alone Emergency Department, specifically for patients with primary mental health conditions. These dedicated units would provide intensive outpatient treatment and observations, stabilize acute mental health symptoms and, when possible, avoid a mental health-related hospitalization.[14]

VHA requires that patients presenting to the Emergency Department for management of mental health complaints be screened for specific risk factors and that the appropriate physical and laboratory screening examinations are completed to assist with diagnosing medical conditions that could be responsible for the mental health condition(s).[15] VHA also requires all its facilities with an Emergency Department to provide safe and secure mental health services during hours of operation and have resources that allow for extended observation or evaluation for up to 23 hours and 59 minutes.[16]

Facility PAOC

Between 2006 and 2018, the facility operated a Psychiatric Emergency Department to "provide stabilizing treatment for all patients presenting with behavioral emergencies, "… and to keep patients with acute mental health needs safe until an appropriate mental health plan for either discharge, admission, or transfer to another facility could be arranged.[17] Facility policy in effect during this timeframe reflected that initial screening for walk-in patients would be completed in the Emergency Department triage area, except for patients being brought in by law enforcement, who would go to the Psychiatric Emergency Department.

In response to the OMI review, the facility changed the name of the Psychiatric Emergency Department to the PAOC in October 2018 to more appropriately classify the outpatient observation care provided to patients with acute mental health needs. Current facility policy describes the PAOC as an outpatient observation setting for patients needing continuous

[14] The Joint Commission; *Quick Safety; Issue 19,* December 2015. Alleviating ED boarding of psychiatric patients. https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_19_Dec_20151.PDF. (The website was accessed on May 14, 2019.)

[15] VHA Directive 1101.05(2), *Emergency Medicine,* September 2, 2016, amended March 7, 2017.

[16] For the purposes of this report, an observation patient is one who has a mental health condition that needs to be monitored, provided with short-term treatment, and reassessed while a decision is made that further treatment in an inpatient setting, or discharge to another care setting, is required.

[17] Facility Policy 116A-013, *Psychiatric Emergency Room/23 Hour Observation Unit*, January 12, 2015.

observation and treatment for acute mental health diagnoses, substance abuse, and/or medical comorbidities, where patients are assessed for imminent risk and ongoing care needs.[18] The policy states that patients cared for in the PAOC are assessed and triaged in the Emergency Department prior to transfer to the PAOC.[19]

The facility's PAOC is located within close proximity to the Emergency Department, allowing for timely access to Emergency Department physicians and services, if needed. Conversely, mental health consults could be requested for Emergency Department patients receiving medical treatment while awaiting transfer to the PAOC.

The PAOC has four observation chairs and includes a separate seclusion area. Nurse staffing in the PAOC consists of three licensed nurses that allows the PAOC to accept a one-to-one seclusion patient in addition to the four observation patients when necessary.[20]

Allegations

In January 2019, the OIG received allegations stating that although some practices related to Emergency Department-based assessment and medical clearance of intoxicated patients and those with mental health conditions had been revised after reviews by TJC and OMI, deficient practices continued. It was also alleged that Emergency Department providers

- Sent patients to the PAOC without medical screening notes;
- Documented that patients had no emergent medical issues, but this conclusion was not based on an assessment or the patient's most current laboratory values or diagnostic studies; and
- Sent patients to the PAOC in active alcohol withdrawal, with blood alcohol levels over 300, and with critical laboratory values.[21] As a result, patients had to be sent directly from the PAOC to a medical unit for medical stabilization. This jeopardized patient safety, delayed care, and contributed to poor outcomes.

[18] Facility Policy 116A-013, *Psychiatric Assessment and Observation Center*, March 19, 2019.

[19] Facility Policy 116A-013.

[20] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017. One-to-one observation is the constant observation of one patient by one staff member. Staff providing one-to one observation should only be observing one patient at a time and have no other responsibilities during the assignment.

[21] The concentration of alcohol in blood correlates directly with the degree of intoxication. The legal limit of intoxication is 80 milligram per deciliter (mg/dL). A concentration of 400 mg/dL or greater is potentially lethal. https://www.mayocliniclabs.com/test-catalog/Clinical+and+Interpretive/8264. (The website was accessed on June 11, 2019.)

To support these allegations, the complainant provided the OIG with the names of 32 patients who received care in the PAOC from August 2017 through December 2018.[22]

Scope and Methodology

The OIG initiated the inspection on April 16, 2019, and conducted a site visit April 22–25.

The OIG interviewed the complainant, the Emergency Department Medical Director and Emergency Department Nurse Manager; the Facility Director, Chief of Staff, and Chief of Mental Health; Emergency Department and mental health providers; PAOC and Emergency Department nursing staff; and others with knowledge of Emergency Department and PAOC operations, policies, and procedures. The OIG team members reviewed relevant facility policies and procedures, staff education and training records, and staff meeting minutes.

The OIG team reviewed the electronic health records (EHRs) for 32 patients provided by the complainant, as well as 205 encounters where the patients presented to the facility's Emergency Department with intoxication or an acute mental health condition and were subsequently transferred to the PAOC between January 1 and March 31, 2019.

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

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

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

[22] The original allegation included 34 patient names; however, the OIG team was unable to find one patient based on the information provided, and another patient was not seen in the PAOC. Those two cases were excluded from further review.

Inspection Results

The Emergency Department Medical Director told the OIG team that prior to August 2018, when the facility was still operating the Psychiatric Emergency Department, medical screening examinations (MSEs) were often completed by Psychiatric Emergency Department staff. Facility policy did not require all patients with primarily mental health concerns to be screened in the Medical Emergency Department first. While the OIG confirmed that some of the conditions as described by the complainant had occurred, those conditions did not conflict with policy and practice in effect at the time.

Specifically, the OIG reviewed the EHRs for the 32 patients identified by the complainant as not receiving adequate MSEs or otherwise not being appropriate for transfer to the PAOC. Those patient encounters occurred between July 2017 and December 2018. Of the 32 patients, 26 did not have a documented MSE prior to transfer to the PAOC; all 26 patient encounters occurred prior to August 2018. Two patients had blood alcohol levels greater than 300.[23] The OIG team also confirmed that one patient had critical laboratory values including a creatine phosphokinase (CPK) of 616 and a potassium of 2.6 while in the PAOC.[24] Those laboratory studies, however, were ordered in the PAOC in accordance with facility policy, not in the Emergency Department as alleged. PAOC staff took appropriate action to ensure the patient received the necessary care.[25]

To assess whether new policies and practices implemented in late 2018 after the OMI and TJC visits were effective, the OIG evaluated 205 encounters of patients who presented to the facility's Emergency Department with intoxication or an acute mental health condition and were subsequently transferred to the PAOC from January 1 through March 31, 2019. The remainder of this report focuses on Emergency Department providers' compliance, at the time of the OIG's

[23] Not all of the patients presented to the Emergency Department with an alcohol-related concern. More than half of the 32 patients did not have an alcohol test completed and/or documented. The team did not find evidence that a patient was transferred to the PAOC with a blood alcohol level of 451 or that a patient with a Clinical Institute Withdrawal Assessment score of 18 was sent to the PAOC as reported by the complainant. The legal limit of intoxication is 80 (mg/dL). The potentially lethal concentration is greater than or equal to 400mg/dL.

[24] CPK is an enzyme in the body, found mainly in the heart, brain, and skeletal muscle. Normal values are 10–120 micrograms per liter. High CPK values may be seen in people who have delirium tremens, heart attack, stroke, or rhabdomyolysis. https://medlineplus.gov/ency/article/003503.htm. (The website was accessed on May 1, 2019.) Potassium is critical to the proper functioning of nerve and muscle cells. Normal blood potassium levels are 3.6 to 5.2. Too much (or too little) potassium in the blood can cause serious heart problems. https://www.kidney.org/atoz/content/what-hyperkalemia. (The website was accessed on July 18, 2019.)

[25] The patient was brought to the Emergency Department in late 2018 by local police due to bizarre, threatening behavior. An Emergency Department provider conducted an MSE that included past medical history and medications. The OIG team found that the provider followed policy and made a reasonable decision to transfer the patient to the PAOC without ordering laboratory studies given the patient's presenting issues.

review, with new Emergency Department assessment and documentation policies for PAOC-bound patients.

1. Medical Screening Examinations

The OIG found that although Emergency Department providers were generally completing MSEs using the new EHR template as required by policy, the MSE template did not require providers to document clinical information used to support their decisions about patient stability for transfer to the PAOC. Therefore, the amount of detailed information documented in the MSE varied by provider.

MSE Completion

The OIG did not substantiate Emergency Department providers sent patients to the PAOC without completing medical screening notes after implementation of the new policy. The Emergency Department Medical Director told the OIG that, per the new policy, Emergency Department providers would document in an MSE note that no medical issues were present that precluded a patient's transfer to the PAOC. [26] If the patient appeared to be intoxicated, a breathalyzer test and Clinical Institute Withdrawal Assessment (CIWA) would be obtained. Other laboratory tests could be requested if indicated.[27] Patients not appropriate for transfer to the PAOC would remain in the Emergency Department and, if needed, a mental health consultation would be requested.

The OIG team reviewed 205 encounters for those patients seen in the Emergency Department and subsequently transferred to the PAOC from January 1 through March 31, 2019. The team found that MSEs were documented as required for 203 of the 205 encounters reviewed.[28]

Sufficiency of MSE and Template Documentation

The OIG substantiated that Emergency Department providers made judgments about patients' medical stability (for example, "no emergent medical issues") without an assessment of

[26] Facility Policy 116A-015, *Interdisciplinary Team and Coordination of Care in the Psychiatric Assessment and Observation Center*, October 11, 2018.

[27] The CIWA Scale is a tool to help clinical personnel recognize the process of withdrawal before it progresses to more advanced stages. Scores of less than 8 indicate minimal to mild withdrawal. Scores of 8–15 indicate moderate withdrawal; scores of 15 or more indicate severe withdrawal. http://www.cbhallc.com/Documents/4a-DETOX%20Guidelines.pdf. (The website was accessed on May 6, 2019.)

[28] One patient refused to cooperate with medical staff; therefore, a medical screening examination could not be completed. One patient did not receive an MSE. Four of the 205 patient encounters had medical conditions identified after transfer to the PAOC that subsequently required medical evaluation or treatment. The OIG's review determined that Emergency Department protocols were followed in these cases.

laboratory values or diagnostic studies; however, laboratory and diagnostic studies were not required by former or current policy.

VHA requires that patients' EHRs contain sufficient record information to serve as a basis to plan patient care, support diagnoses, and warrant treatment.[29] However, VHA does not specify what constitutes a comprehensive MSE or what components are required to be documented.

In August 2018, the Emergency Department implemented the use of a templated MSE note allowing the provider to select one of the following options:

- "The patient requires additional evaluation in the Medical Emergency Department."
- "The patient does NOT have an emergency medical condition. In my opinion, it is safe to refer this patient to a clinic for specialty care services for definitive care."
- "The patient does NOT have an emergency medical condition; this patient does have an emergency psychiatric condition requiring continued evaluation in our psychiatric intervention area."

While the template offered a free text section for comments, it was not a required field. Further, the statement "The patient does NOT have an emergency medical condition" within the template did not require the provider to document pertinent history, physical examination, or other clinical findings. The OIG concluded that the MSE template's checkbox format, coupled with the lack of guidance outlining the elements of an acceptable MSE, may limit analysis of the patient's conditions and result in delays in diagnosis and treatment. For example, the OIG identified a patient who, based on the Emergency Department provider's documentation, did not appear to be adequately assessed for medical stability prior to transfer to the PAOC.

> *The patient presented to the facility's Emergency Department in early 2019 for suicidal ideation and the inability to stop drugs and alcohol use. The patient told the triage nurse that the last use of drugs and alcohol was in the early morning. The Emergency Department physician documented the patient's history of recent drug and alcohol use, CIWA score of 6, breathalyzer of zero, and indicated that the patient did not have an emergent medical condition but needed mental health evaluation. The Emergency Department physician documented the patient's MSE after the patient transferred to the PAOC.*
>
> *After arrival in the PAOC, the resident ordered bloodwork that included a CPK, which came back with an elevated level of 573. The patient was transferred to the*

[29] VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

medical unit for management and monitoring of rhabdomyolysis.[30] After three days of treatment on the medical unit, the patient's CPK normalized with intravenous fluids, and the patient was transferred to the inpatient mental health unit.

The patient's history included recent use of drugs and alcohol, yet the Emergency Department physician did not document the extent of the patient's substance use or document details regarding the amount of drug or alcohol used prior to the Emergency Department visit. This information, had it been obtained, could have prompted the provider to order laboratory studies to assess for medical conditions requiring further evaluation. In this case, the Emergency Department provider did not document a sufficient history and physical examination, or complete a medical workup, to establish the patient's medical stability prior to transfer to the PAOC. While the patient ultimately received appropriate and timely care, inadequate Emergency Department screening has the potential to place patients at risk for adverse clinical outcomes.[31]

2. Care of Intoxicated Patients

Alcohol Withdrawal

The OIG did not substantiate that patients were transferred to the PAOC in active alcohol withdrawal. Of the 205 encounters with documented CIWA scores, none of the patients were transferred to the PAOC with a CIWA score higher than 8 (scores of less than 8 indicate minimal to mild withdrawal). The OIG determined that caring for patients in various stages of active alcohol withdrawal was within the scope of what is traditionally managed by mental health professionals.

In March 2019**,** the facility issued a policy that defined the procedures for evaluation and treatment of patients presenting with suspected substance intoxication and mandatory CIWA training for all Emergency Department and PAOC staff had occurred.[32]

Elevated Blood Alcohol Levels

Of the 205 patient encounters included in the OIG's review, none were transferred with blood alcohol levels greater than 300.

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[30] Rhabdomyolysis is a rare condition in which muscle cells break down and release a substance into the blood that can lead to kidney failure. https://newsnetwork.mayoclinic.org/discussion/variety-of-causes-can-be-at-root-of-rhabdomyolysis. (The website was accessed on May 22, 2019.)

[31] The OIG also noted that the Emergency Department physician documented the patient's medical stability after the patient was transferred to the PAOC. It is possible that the Emergency Department physician entered the MSE note late.

[32] Facility Policy 116A-017, *Management of Patients with Suspected Substance Intoxication*, March 1, 2019.

Facility policy states that patients suspected to be clinically intoxicated will be offered a thorough clinical assessment by qualified clinicians who will evaluate the patient's condition and devise the appropriate management plan. The OIG was told that the PAOC unit managed patients who needed continuous observation and/or treatment for an acute psychiatric condition or substance abuse, which may include a medical issue. The PAOC clinicians conducted assessments of clinically intoxicated patients and decided if the patients could be cared for in the PAOC, needed to be transferred back to the Emergency Department for treatment, or needed admission to an inpatient medical bed for detoxification. The assessment and treatment of clinically intoxicated patients was based on medical history, comorbidities, history of substance use, medications, and other clinical factors, not on blood alcohol levels.

Critical Laboratory Values

The OIG did not substantiate that patients were transferred from the Emergency Department to the PAOC with critical laboratory values. Of the 205 encounters, Emergency Department providers ordered laboratory tests for 29 patients. Four of the 29 patients had abnormal or critical laboratory results; three of the four patients were treated in the Emergency Department. The fourth patient was transferred from the Emergency Department to the PAOC with a high blood glucose level of 302, although the team could not determine with certainty whether clinical providers believed that it was a critical value.[33] A blood glucose level of 302 milligram per deciliter (mg/dL) in a patient with diabetes may be treated in a variety of ways, including insulin and hydration.[34] The Emergency Department provider acknowledged the high blood glucose level and documented that insulin would be provided in the PAOC. The patient's blood glucose, which was retaken in the PAOC, was 251 mg/dL and insulin was not administered.[35]

The OIG did not substantiate that the facility's policies or practices related to Emergency Department care of intoxicated patients or those with mental health conditions jeopardized patient safety, delayed care, or contributed to poor outcomes. While the OIG determined that Emergency Department providers conducted limited work-ups and sent these patients to the PAOC for more thorough assessments, this practice complied with facility policy. The patients received appropriate care and did not experience adverse clinical outcomes.

[33] High blood glucose levels (hyperglycemia) affects people who have diabetes. Hyperglycemia may cause symptoms when glucose values are elevated usually above 180 to 200 mg/dL. https://www.mayoclinic.org/diseases-conditions/hyperglycemia/symptoms-causes/syc-20373631. (The website was accessed on July 18, 2019.)

[34] Diabetes refers to a group of diseases that affect how the body uses blood sugar (glucose). https://www.mayoclinic.org/diseases-conditions/diabetes/symptoms-causes/syc-20371444. (The website was accessed on July 18, 2019.)

[35] The patient's EHR did not include specific documentation of the reason why insulin was not administered in the PAOC. However, the PAOC physician acknowledged the glucose level, the patient was asymptomatic, and elevated glucose levels can be treated in a variety of ways that does not include the administration of insulin.

Conclusion

The OIG confirmed many of the allegations in the context of practices that were in place between 2016 and 2018. Specifically, the OIG confirmed the allegation that patients presenting to the Emergency Department with intoxication or other mental health complaints were not being properly assessed and medically cleared in the Emergency Department before transfer to the then-Psychiatric Emergency Department (predecessor to the PAOC). The OIG also confirmed that Emergency Department providers were not consistently completing MSE notes before patients were transferred. After visits by TJC and the OMI, the facility implemented a new policy on MSEs, and in August 2018, the Emergency Department implemented the use of a templated MSE note that allowed Emergency Department providers to select from several different "checkbox" options.

The OIG did not substantiate that, after implementation of the new MSE policy, patients were being sent from the Emergency Department to the PAOC without MSE notes. The OIG's review of 205 patient encounters occurring after January 1, 2019, reflected nearly 100-percent compliance with new MSE policy. However, while the templated note offered a free text option, it was not a required field and providers were not required to document pertinent history, physical examination, or other clinical information to support the decision that a patient did not have an emergency medical condition. The OIG concluded that in the absence of guidance outlining the elements of an acceptable MSE, the templated checkbox format may limit analysis of the patient's condition, resulting in potential delays in diagnosis and treatment. Nevertheless, the OIG found no evidence of adverse patient outcomes related to the management of patients receiving care in the PAOC.

Recommendation 1

The Louis Stokes Cleveland VA Medical Center Director defines what elements are required for a medical screening exam to deem a patient medically stable prior to transfer to the Psychiatric Assessment and Observation Center.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 11, 2019

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

Subj: Healthcare Inspection—Emergency Department Care of Intoxicated Patients and Those with Mental Health Conditions, Louis Stokes Cleveland VA Medical Center, Ohio

To: Director, Office of Healthcare Inspections, Rapid Response Team (54RR00)
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. I have reviewed and concur with the findings and recommendations in the OIG report entitled, "Emergency Department Care of Intoxicated Patients and Those with Mental Health Conditions, Louis Stokes Cleveland VA Medical Center, Ohio."
2. If you have any questions or concerns, please contact Lisa Pyle, Quality Management Officer at (513) 247-2838.

(*Original signed by*:)

SHELLA STOVALL, MNA, RN
Acting Network Director, VISN 10

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 11, 2019

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

Subj: Healthcare Inspection—Emergency Department Care of Intoxicated Patients and Those with Mental Health Conditions, Louis Stokes Cleveland VA Medical Center, Ohio

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

1. I have reviewed and concur with the findings and recommendation in the OIG report entitled, "Emergency Department Care of Intoxicated Patients and Those with Mental Health Conditions, Louis Stokes Cleveland VA Medical Center, Ohio."
2. A corrective action plan has been established and a target completion date has been set.

(Original signed by BRIAN CMOLIK, MD, *acting for*:)

CANDACE IFABIYI
Medical Center Director

Facility Director Response

Recommendation 1

The Louis Stokes Cleveland VA Medical Center Director defines what elements are required for a medical screening exam to deem a patient medically stable prior to transfer to the Psychiatric Assessment and Observation Center.

Concur.

Target date for completion: November 30, 2019

Director Comments

The electronic medical screening exam template was revised by the Clinical Application Coordinators to include mandatory fields for screening history, physical examination, and assessment with plan. The revised template continues to allow providers the ability for narrative documentation that accurately reflects appropriate screening for medical stability, but forces compliance with all required elements of the medical screening exam. The Quality Management department will complete monthly chart audits of the revised template until 90% compliance is sustained for 3 consecutive months. Audit results will be given to the Medical Director, Emergency Department on a weekly basis. Compliance below 90% will be reported to the Executive Leadership Board.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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