



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

A Delay in Patient  
Notification of Test Results  
and Other Communication  
Issues at the Bath VA  
Medical Center  
New York



The mission of the Office of Inspector General is to serve veterans and the public by conducting effective oversight of the programs and operations of the Department of Veterans Affairs through independent audits, inspections, reviews, and investigations.

*In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.*

**Report suspected wrongdoing in VA programs and operations  
to the VA OIG Hotline:**

[www.va.gov/oig/hotline](http://www.va.gov/oig/hotline)

**1-800-488-8244**



## Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations of (1) delays in providing patient test results, (2) communication issues between providers and paramedics related to transporting patients to a community hospital emergency department, (3) violations of the Emergency Medical Treatment and Labor Act (EMTALA), and (4) quality of care concerns resulting from paramedic care at the Bath VA Medical Center (facility), New York.<sup>1</sup>

The OIG reviewed a total of 13 patients and grouped the patients for discussion according to the allegations. Because certain aspects of a patient's care may have fallen under more than one allegation, the same patient may be discussed in multiple categories.<sup>2</sup>

The OIG substantiated that one of two patients experienced a delay in receiving positive stress test results.<sup>3</sup> In summer 2017, a cardiologist followed facility policy by electronically notifying the ordering provider and the surrogate provider of the positive stress test within an appropriate time, but the surrogate provider did not notify the patient.<sup>4</sup> The surrogate provider forwarded the notification to the Chief of Staff 28 days after receiving it. The Chief of Staff then notified the patient eight days after receiving the notification. The patient did not experience an adverse event; however, a significant delay of 36 days elapsed from when the cardiologist provided the positive test results to the ordering provider and surrogate provider to when the patient received the test results.<sup>5</sup>

A second patient underwent a stress test in late summer 2018. Although the OIG substantiated that the cardiologist dictated the patient's stress test report late in the day and that the report was not transcribed until the next day, the OIG concluded that the cardiologist documented, dictated, and informed the primary care provider of the results in a timely manner. The primary care

---

<sup>1</sup> The allegation also included patient abuse. The OIG incorporated patient abuse into the four allegations. EMTALA requires hospitals to provide emergency care regardless of a patient's ability to pay. EMTALA requires most hospitals to provide an evaluation and stabilization treatment without regard of the patient's insurance status or ability to pay.

<sup>2</sup> From the total number of patient cases (18), the OIG excluded five from further review (four lacked sufficient information to identify the patient, and one patient's care was provided by community paramedics, not VA paramedics). Prior to the OIG review, the facility conducted internal reviews on all the patient cases, except for Patients 10 and 11.

<sup>3</sup> A stress test is a diagnostic and prognostic tool for assessing patients with suspected ischemic heart disease. When exercised, coronary blood flow must increase to the higher demands of the heart muscle. Limited coronary blood flow may result in EKG changes. Jonathan Hill and Adam Timmis, "ABC of clinical electrocardiography," *British Medical Journal*, vol. 324 (May 2002): 1084–7.

<sup>4</sup> The OIG was unable to interview the surrogate provider because the provider no longer worked for VA.

<sup>5</sup> VHA defines an adverse event as an "untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences."

provider informed the patient of the test results within the required time frame. Whether the patient was informed of the tests results by the cardiologist on the test date is unknown. The OIG was unable to determine if the cardiologist read this patient's stress test before or after the patient left the building.

The OIG substantiated a communication issue occurred between a provider and a paramedic in one of the two reviewed cases. Although a facility provider documented and reported telling the paramedic that the patient should be transported to a community hospital that was further from the facility because the nearest community hospital lacked the necessary equipment, the paramedic transported the patient to the nearest community hospital. The paramedic told the OIG that the patient was transported to the nearest community hospital because the paramedic had already spoken with hospital staff who had accepted the patient. By failing to follow the provider's instructions, the paramedic was not in compliance with the facility's standard operating procedure.

When reviewing the facility's transfer policy relative to this issue, the OIG team noted that the policy did not clearly define a process for outpatient transfers to a higher level of care utilizing facility paramedics.

The OIG did not substantiate that facility paramedics violated the intent of EMTALA by transporting either of the two reviewed patients to a community hospital emergency department. Facility providers medically screened and provided care to the two reviewed patients prior to transfer.

The OIG did not substantiate that facility paramedics provided poor quality of care to the 10 reviewed patients. The paramedics asked suitable and clarifying questions of the providers, assessed the patients, and documented their findings.

The OIG made two recommendations to the Facility Director to ensure that surrogate providers comply with their responsibilities to notify patients of test results when providing coverage and that the Patient Transfer Policy clearly defines a process for outpatient transfers to a higher level of care utilizing facility paramedics.

## Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan (see appendixes B and C). The OIG will follow up on the planned actions until they are completed.



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

## Contents

Executive Summary .....	i
Abbreviations .....	iv
Introduction.....	5
Scope and Methodology .....	7
Inspection Results .....	8
1. Delays in Patient Notification of Test Results .....	8
2. Communication Issues Related to Patient Transport .....	9
3. Alleged EMTALA Violations.....	10
4. Alleged Quality of Care Concerns Resulting from Paramedic Care.....	11
Conclusion .....	11
Recommendations 1–2.....	12
Appendix A: Patient Case Summaries.....	13
Appendix B: VISN Director Memorandum.....	21
Appendix C: Facility Director Memorandum.....	22
OIG Contact and Staff Acknowledgments .....	24
Report Distribution .....	25

## Abbreviations

DVT	deep venous thrombosis
EHR	electronic health record
EKG	electrocardiogram
EMT	emergency medical technician
EMTALA	Emergency Medical Treatment and Labor Act
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



## Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations of (1) delays in providing patient test results, (2) communication issues between providers and paramedics related to transporting patients to a community hospital emergency department, (3) violations of the Emergency Medical Treatment and Labor Act (EMTALA), and (4) quality of care concerns resulting from paramedic care at the Bath VA Medical Center (facility), New York.<sup>6</sup>

## Facility Background

In October 2018, the facility merged with the Canandaigua VA Medical Center to form the VA Finger Lakes Health Care System. The VA Finger Lakes Health Care System is part of Veterans Integrated Service Network (VISN) 2 and operates five community clinics. Between October 1, 2017, and September 30, 2018, the facility served 13,745 patients and had a total of 275 hospital operating beds, including 10 inpatient beds, 170 domiciliary beds, and 95 community living center beds.

The facility provides urgent care services for patients in need of immediate attention and/or with minor injuries at its Urgent Care Center that is open seven days a week, 8:00 a.m. to 8:00 p.m. It does not operate an emergency department or accept emergency ambulances. The facility advises patients to seek care at their closest emergency department for any condition that requires care and services beyond what the Urgent Care Center can provide.<sup>7</sup> The closest emergency department to the facility is located approximately five miles away.

## VA Firefighters and Paramedics

Of the VA's 170 medical centers, 20 have fire departments; six of the 20 fire departments provide paramedic services.<sup>8</sup> VA has specific requirements that community fire departments must meet in order "to be considered adequate for the protection of a VA medical facility in

---

<sup>6</sup> The allegation also included patient abuse. The OIG incorporated patient abuse into the four allegations. EMTALA requires hospitals to provide emergency care regardless of a patient's ability to pay. EMTALA requires most hospitals to provide an evaluation and stabilization treatment without regard of the patient's insurance status or ability to pay.

<sup>7</sup> Medical Center Memorandum 200-001-203, *Urgent Care Clinic*, December 2016.

<sup>8</sup> The six VA medical centers with paramedics include Bath, New York; Battle Creek, Michigan; Castle Point, New York; Lyons, New Jersey; Martinsburg, West Virginia; and Tuskegee, Alabama.

which patients are housed overnight.”<sup>9</sup> If a community fire department is unable to meet the VA requirements, the VA medical facility will establish, train, and maintain a VA fire department.<sup>10</sup>

The main obligation of VA fire departments is to respond to fires.<sup>11</sup> Additional services the fire departments may provide include responding to emergencies that occur on campus and providing basic and advanced life support ambulance transport.<sup>12</sup> VA requires the presence of either an emergency medical technician (EMT)-basic or EMT-paramedic (paramedic) for off-campus ambulance transports.<sup>13</sup>

## Facility Firefighters and Paramedics

The facility has 18 firefighters; nine are EMTs-basic and nine are paramedics. The Fire Chief and assistant fire chiefs provide direct supervision to the firefighters. When the firefighters are acting as paramedics, they receive direction and medical oversight from the Chief of the Urgent Care Center.<sup>14</sup> Facility paramedics provide basic life support training to staff, respond to emergency calls, provide out of operating room airway management, and perform routine safety checks. The facility’s Fire Department has a Mutual Aid Plan Memorandum of Understanding with the local community to provide services in the community, as needed.

## EMTALA and VA Hospitals

EMTALA ensures access to emergency services regardless of ability to pay. EMTALA requires Medicare-participating hospitals that offer emergency services to provide a medical screening examination when a request is made for examination or treatment for an emergency medical condition, regardless of an individual’s ability to pay. If a hospital is unable to stabilize a patient or if the patient requests, an appropriate transfer should be implemented.

Veterans Health Administration (VHA) Directive 1101.05(2), *Emergency Medicine*, states “[w]hile not technically subject to EMTALA and the regulations implementing the Act issued by

---

<sup>9</sup> VHA Handbook 7701.02, Fire Department Services at VA Medical Centers and Domiciliaries, December 29, 2015.

<sup>10</sup> VHA Handbook 7701.02.

<sup>11</sup> VHA Handbook 7701.02.

<sup>12</sup> An EMT-basic can perform cardiopulmonary resuscitation, clear and open an airway, and use an automated external defibrillator in people without a pulse or who are not breathing. A paramedic can use invasive techniques such as intubation, insert intravenous lines, and administer medications.

<https://healthresearchfunding.org/difference-between-emt-and-paramedic/>. (The website was accessed on October 29, 2019.)

<sup>13</sup> VHA Handbook 7701.02. An EMT-basic has the training to use basic life support techniques.

<sup>14</sup> Medical Center Memorandum 600-FIRE-285, *Emergency Medical Service (EMS) Program*, September 2016. When providing medical oversight, the Chief of Urgent Care, or designee, is often referred to as the medical control physician. The Chief of Urgent Care is also responsible for authorizing treatment protocols and quality assurance activities for paramedics.



the Centers for Medicare and Medicaid Services (CMS), VHA complies with the intent of EMTALA requirements.”<sup>15</sup>

## **Allegations**

On January 16, 2019, the OIG received allegations related to delays in providing patient test results, communication issues between providers and paramedics related to transporting patients to a community hospital emergency department, EMTALA violations, and quality of care resulting from facility paramedic care.

On February 12, 2019, the OIG initiated a hotline after a preliminary review of the electronic health records (EHRs) of the patients who were identified in the allegations. Over the course of the inspection, the OIG team received additional patient cases for review.<sup>16</sup>

## **Scope and Methodology**

The OIG initiated the inspection on February 21, 2019, and conducted a site visit the week of April 8, 2019.

The OIG team reviewed 13 patients’ EHRs, and interviewed facility leaders; Chiefs of Medicine, the Urgent Care Center, and the Fire Department; the Risk Manager; the Patient Safety Manager; paramedics and firefighters; and relevant clinical staff. The OIG team reviewed applicable VHA directives and handbooks; facility policies and procedures; Code Blue Committee meeting minutes; fact-finding reports; administrative actions; and facility paramedics’ competencies, certifications, and position descriptions; and pertinent medical literature.

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.

---

<sup>15</sup> VHA Directive 1101.05(2), *Emergency Medicine*. September 2, 2016, amended March 7, 2017.

<sup>16</sup> The OIG initially received information related to 16 cases concerning quality of care. Subsequently, the OIG received another two cases with potential patient safety deficiencies. The OIG excluded five cases from review: four due to insufficient patient information and one because the patient received care from non-VA paramedics rather than VA paramedics. The OIG reviewed the remaining 13 patients and grouped them for discussion according to the allegations. Because certain aspects of a patient’s care may have fallen under more than one allegation, the same patient may be discussed in multiple categories.

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.

## Inspection Results

### 1. Delays in Patient Notification of Test Results

The OIG substantiated a 36-day delay in providing an abnormal stress test result to one of the two patients at issue. Appendix A contains details of the two patient case summaries (Patients 1 and 2).<sup>17</sup> Test results for the second patient were timely dictated, documented, and conveyed to the ordering provider and the patient.

VHA and facility policies require that the ordering provider notify the patient of critical, urgent, or clinically significant test results that require therapeutic intervention or action within seven days of being notified of the test results, and document the discussion.<sup>18</sup> If the ordering provider is unavailable, VHA and the facility require that a process be in place that identifies a surrogate provider to receive and address test results, as needed. If a surrogate provider is not identified or available, then test results should be reported to the ordering provider's service chief or an equivalent supervisor. Facility policy states that the diagnostic provider (the provider who performs or supervises the test) can communicate abnormal test results to the ordering provider or the surrogate provider through either direct (in-person or telephone call) or electronic (alerts or email) communication.<sup>19</sup>

#### Patient 1

The patient underwent a stress test in summer 2017. A facility cardiologist (the diagnostic provider) followed facility policy by electronically notifying the ordering provider and the surrogate provider of the abnormal stress test within an appropriate time frame. However, neither the ordering provider nor the surrogate provider notified the patient of the abnormal test results within the required seven-day time frame.<sup>20</sup> The surrogate provider forwarded the notification to the Chief of Staff 28 days after being notified, and the Chief of Staff contacted the patient eight days after receiving the test results. Although the patient did not experience an adverse event, a

---

<sup>17</sup> A stress test is an important diagnostic and prognostic tool for assessing patients with suspected ischemic heart disease. When exercised, coronary blood flow must increase to the higher demands of the heart muscle. Limited coronary blood flow may result in EKG changes. Jonathan Hill and Adam Timmis, "ABC of clinical electrocardiography," *British Medical Journal*, vol. 324 (May 2002): 1084–7.

<sup>18</sup> VHA Handbook 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015. Medical Center Memorandum 600-011-329, *Notification and Reporting of Patient Test Results*, March 2017, updated December 8, 2017.

<sup>19</sup> Medical Center Memorandum 600-011-329.

<sup>20</sup> The OIG was unable to interview the surrogate provider because the provider no longer worked for VA.

delay of 36 days elapsed from when the cardiologist provided the stress test results to the ordering provider and the surrogate provider until the patient received the test results.<sup>21</sup>

In December 2017, the facility revised its notification of test results policy to include the following changes:

All positive stress tests and echocardiograms require same day direct communication with the ordering provider or surrogate or by the first business day if the study is read on an off-tour, weekend, or holiday.<sup>22</sup>

The OIG did not make a recommendation related to the notification of test results because the facility revised its policy following this delay.

## **Patient 2**

The second patient at issue underwent a stress test in late summer 2018. The cardiologist documented an addendum to the primary care provider's note and dictated the results of the stress test, the day the test was conducted. The transcription was completed the following day. In addition, the cardiologist called the primary care provider to discuss the patient's stress test results on the day the transcription was completed. The primary care provider notified the patient of the stress test results within the required time frame. Within three days of the positive stress test, the patient underwent a cardiac catheterization.

Whether the patient was informed of the tests results by the cardiologist on the date of the stress test is unknown. The OIG was unable to determine if a facility cardiologist read this patient's stress test before or after the patient left the building. The cardiologist added an addendum on the evening of the test date, and the cardiology technician documented on the following day, "[s]tress test completed on [date] reviewed by [c]ardiologist." Although the cardiology technician could not remember this patient, the cardiology technician reported to the OIG that it was the cardiologist's practice to review stress test results prior to the patient leaving the exam room, and if there was a concern, the cardiologist would speak with the patient.

## **2. Communication Issues Related to Patient Transport**

### **Communication between Provider and Paramedic**

The OIG substantiated that a communication issue occurred between a provider and a paramedic related to transporting one of the two reviewed patients (Patients 3 and 4) to a community

---

<sup>21</sup> VHA defines an adverse event as an "untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences."

<sup>22</sup> Medical Center Memorandum 600-011-329.

hospital emergency department. (Appendix A contains details of the two patient case summaries.)

For one of the two patients at issue (Patient 3), a facility provider documented and reported telling the paramedic that the patient should be transported to a community hospital that was further from the facility because the nearest community hospital to the facility lacked the necessary equipment. The paramedic told the OIG that the patient was transported to the nearest community hospital because the paramedic had already spoken with hospital staff who had accepted the patient.<sup>23</sup>

By failing to follow the provider's instructions, the paramedic was not in compliance with the facility's standard operating procedure.<sup>24</sup> The OIG did not make a recommendation related to a paramedic transporting the patient to the nearest community hospital emergency department because the facility addressed the concern.

Based on an EHR review of the second patient at issue (Patient 4), the OIG concluded that the providers reconsidered where the paramedics should transport the patient due to the patient's medical condition and the paramedics complied with the provider's updated instructions.

### **Additional Finding: Transport Policy**

VHA requires VA medical facilities to ensure maximum patient safety and compliance with the intent of the transfer provision of EMTALA when transferring inpatients or patients in an emergency department/urgent care center into or out of a VA medical facility.<sup>25</sup> VHA also requires that facility directors ensure that "a written policy is in effect to ensure the safe, appropriate, orderly, and timely transfer of patients."<sup>26</sup> During the review of these patients, the OIG noted that the facility's Patient Transfer Policy did not clearly define a process for outpatient transfers to a higher level of care utilizing facility paramedics.

## **3. Alleged EMTALA Violations**

The OIG did not substantiate that facility paramedics failed to meet the intent of EMTALA, as required by VHA Directive 1101.05(2), *Emergency Medicine* for two patients (Patients 3 and 5). As per the directive, VA facilities, although not subject to EMTALA, must comply with the

---

<sup>23</sup> The OIG considered categorizing this patient case as a quality of care concern, but given that (1) the patient was later transferred to a community hospital's emergency department with the necessary equipment and treated accordingly, and (2) the concern was resolved and appeared to be more of a performance and administrative issue rather than a systemic issue affecting patient safety, the OIG categorized this patient case as a communication issue.

<sup>24</sup> Bath VA Medical Center Fire and Emergency Service, EMS Procedures, E002, *Ambulance Operations*, August 2005, revised October 2015.

<sup>25</sup> VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.

<sup>26</sup> VHA Directive 1094.

regulations. Under those auspices, the OIG evaluated the allegation of EMTALA violations based on VHA's directive and the intent of EMTALA.<sup>27</sup> The OIG found the two patients at issue were screened and transported to a community hospital emergency department in alignment with EMTALA requirements. (Appendix A contains details of the two patient case summaries.)

#### **4. Alleged Quality of Care Concerns Resulting from Paramedic Care**

The OIG did not substantiate that facility paramedics provided care that resulted in poor quality of care for the 10 reviewed patients. (Appendix A contains details of the 10 patient case summaries.)

VHA defines quality of care as having four characteristics:

the right type of care for the patient's health condition; care that results in the best possible outcome for the patient; care delivered with the attention to the patient's concerns, needs, and life goals; and care that keeps the patient safe from hazards and harm.<sup>28</sup>

The OIG evaluated the EHRs of the 10 reviewed patients and spoke with the Risk Manager, the Patient Safety Manager, and the Chief of Urgent Care. For these 10 reviewed patients, the paramedics responded to the emergency calls, spoke with staff about the patients' conditions, assessed the patients, and conferred with the providers and the medical control physician, as needed, to determine where to transport patients. Based on the interviews conducted and analysis of the 10 reviewed patients' EHRs, the OIG determined that paramedics asked suitable and clarifying questions of providers, assessed patients, and documented their findings.

## **Conclusion**

The OIG substantiated that one of two patients under review who underwent a stress test, experienced a delay in receiving positive stress test results. The cardiologist followed facility policy by electronically notifying the ordering provider and the surrogate provider of the positive stress test within the appropriate time, but the surrogate provider did not notify the patient. The surrogate provider forwarded the notification 28 days after receiving it to the Chief of Staff. The Chief of Staff then notified the patient eight days later. The patient did not experience an adverse event; however, a significant delay of 36 days elapsed from when the cardiologist provided the positive test results to the provider and surrogate provider to when the patient received the test results.

The OIG substantiated a communication issue occurred between a physician and a paramedic in one of two reviewed cases related to transport issues. Although a facility provider documented

---

<sup>27</sup> VHA Directive 1101.05(2), *Emergency Medicine*. September 2, 2016, amended March 7, 2017.

<sup>28</sup> "Quality of Care," VA, <https://www.va.gov/qualityofcare/>. (The website was accessed on October 30, 2019.)

and reported telling the paramedic that the patient should be transported to a community hospital that was further from the facility because the nearest community hospital lacked the necessary equipment, the paramedic transported the patient to the nearest community hospital. By failing to follow the provider's instructions, the paramedic was not in compliance with the facility's standard operating procedure. As the facility addressed the communication issue between the provider and the paramedic prior to the OIG team's visit, a recommendation was not made on this matter.

The OIG determined the facility's Patient Transfer Policy did not clearly define a process for outpatient transfers to a higher level of care utilizing facility paramedics. The OIG did not substantiate that facility paramedics violated the intent of EMTALA by transporting either of the two reviewed patients to a community hospital emergency department. Facility providers medically screened and provided care to the two reviewed patients prior to transfer.

The OIG did not substantiate that facility paramedics provided poor quality of care to the 10 reviewed patients. The paramedics asked suitable and clarifying questions of providers, assessed patients, and documented their findings.

## **Recommendations 1–2**

1. The Bath VA Medical Center Director ensures that surrogate providers comply with the facility's notification policy when providing coverage.
2. The Bath VA Medical Center Director ensures that the Bath VA Medical Center Patient Transfer Policy clearly defines a process for outpatient transfers to a higher level of care utilizing facility paramedics.

## Appendix A: Patient Case Summaries

### Patient 1 (Delays in Providing Test Results to Patients)

In late spring 2017, during a follow-up appointment, a patient in their late sixties informed the assigned primary care provider of a two-month history of shortness of breath occurring with physical activity.<sup>29</sup> The provider obtained an electrocardiogram (EKG) and scheduled the patient for a stress test.<sup>30</sup> A medical technician performed the stress test 17 days after the follow-up appointment. Four days later a cardiologist interpreted and documented the results of the stress test as abnormal based on ST segment criteria that was associated with “dyspnea and frequent premature ventricular contractions on the monitor” during the test.<sup>31</sup>

According to documentation provided by the facility, the ordering provider had designated a surrogate. The ordering provider and the surrogate provider received an electronic notification of a cardiology note and the stress test results four and five days after the stress test, respectively; however, the OIG found no evidence that the ordering provider or the surrogate provider reviewed the documentation or contacted the patient with the test results. Based on the provided documentation, the Chief of Staff received notification of the stress test results 32 days after the test. Eight days later, the Chief of Staff contacted the patient and documented that the patient stated, “was never told of the positive stress test” and was “still having exertional SOB [shortness of breath] and feeling tired.” On the same day, the Chief of Staff entered a “stat consult” for scheduling a cardiac catheterization at another VA medical center.<sup>32</sup> The other VA medical center discontinued the consult the day after it was entered because its cardiac catheterization lab was closed. That same day, the Chief of Staff entered a cardiology consult and two days later, a facility cardiologist met with the patient. The facility cardiologist started the patient on a medication for angina and entered a consult for a cardiac catheterization at a

---

<sup>29</sup> The OIG uses the singular form of they (their/them) to protect patients’ privacy.

<sup>30</sup> An EKG provides a graphic tracing of the flow of the electrical impulse as it travels through the heart to cause contraction, which pumps blood from the heart, and relaxation, which allows the heart to fill again. Providers use an EKG to help diagnose a variety of heart issues related to rhythm, muscle damage from myocardial infarctions (heart attacks), and other problems. Venes D, *Taber’s Cyclopedic Medical Dictionary*, 22<sup>nd</sup> ed, January 1, 2013.

<sup>31</sup> The ST segment, “represents the period in which the myocardium maintains contraction to expel blood from the ventricles.” Anthony H. Kashou, Hajira Basit, and Ahmed Malik, “ST Segment,” updated May 13, 2019, Stat Pearls Publishing, LLC (internet). [Stat Pearls, ST-segment, NCBI. nlm.nih.gov/books](https://www.ncbi.nlm.nih.gov/books/StatPearls/ST-segment). Positive ST segment criteria in association with a stress test indicates that during exercise the ST segment of the EKG tracing was observed to be horizontal or down sloping, the most reliable indicator of exercise-induced ischemia (deficient supply of blood flow due to an obstruction). Jonathan Hill and Adam Timmis, “ABC of clinical electrocardiography,” *British Medical Journal*, vol. 324 (May 2002): 1084–7. Dyspnea means difficult or labored respiration. <https://www.merriam-webster.com/dictionary/dyspnea>. (The website was accessed on June 12, 2019.)

<sup>32</sup> Cardiac catheterization is a medical procedure in which a thin, flexible catheter is inserted through an artery or vein and passed into the heart for the diagnosis and treatment of heart conditions. <https://www.merriam-webster.com/dictionary/cardiac%20catheterization>. (The website was accessed on June 10, 2019.)

different VA medical center.<sup>33</sup> During the cardiac catheterization 12 days after the Chief of Staff entered the consult, the other VA medical center cardiologist performed a percutaneous coronary intervention of two coronary arteries.<sup>34</sup>

## **Patient 2 (Alleged Delays in Providing Test Results to Patients)**

During a primary care clinic appointment in late summer 2018, a patient in their late sixties complained of chest pain in the center of the chest, described as pressure and heartburn, non-radiating, when lifting heavy objects or walking briskly up a steep hill. The primary care provider entered a cardiology consult for a stress test. The patient underwent a stress test 13 days later, and the cardiologist entered recommendations and an addendum note to the primary care provider's note with the test results. The next day the cardiologist called the primary care provider to report that the stress test was positive and recommended consideration of a cardiac catheterization or pharmacologic stress test with imaging. The patient underwent a cardiac catheterization three days after the stress test.

## **Patient 3 (Communication Issues and Alleged EMTALA Violations)**

A patient in their mid-fifties entered the facility's Domiciliary Residential Rehabilitation Treatment Program (domiciliary) in summer 2018.<sup>35</sup> The month following entry, the patient complained to the nurse about right biceps swelling with pain that had become constant. The nurse contacted the medical officer of the day and discussed the patient's symptoms. The medical officer of the day prescribed tramadol and warm and cold packs that day, but the patient was "without relief."<sup>36</sup> The medical officer of the day saw the patient and noted the worsening symptoms and the patient's wish to go to an emergency room for further evaluation. After examining the patient, the medical officer of the day was concerned as to the possibility of a deep venous thrombosis (DVT) in a vein of the right upper extremity and advised the paramedic to transport the patient to a specific community hospital emergency department.<sup>37</sup> However, the

---

<sup>33</sup> Angina denotes chest pain induced by insufficient blood flow in the blood vessels of the heart.

<sup>34</sup> Percutaneous coronary intervention is a procedure where a cardiologist places a small tube in a clogged blood vessel of the heart to improve blood flow.

<sup>35</sup> A domiciliary provides 24-hours-per-day, 7 days-per-week, structured and supportive residential environment as a part of the rehabilitative treatment regime for patients with medical, psychiatric, substance use disorders, post-traumatic stress disorder, and homelessness. VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010. This Handbook was rescinded and replaced with VHA Directive 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, July 15, 2019, which contains similar language.

<sup>36</sup> Tramadol is an opioid used in the management of moderate to moderately severe pain.

<sup>37</sup> DVT is a blood clot forming in a deep vein; relatively few DVTs are located in the upper extremities; a DVT can lead to complications such as a clot migrating to the lung, which carries a high mortality.



paramedic transported the patient to the nearest community hospital, which did not have the necessary equipment to evaluate the patient for a possible DVT.

According to documentation and OIG interviews, the OIG ascertained that the medical officer of the day went out to the ambulance and told the paramedic that the patient should not go to the nearest community hospital but needed to go to another community hospital because the nearest community hospital did not have the right equipment. The medical officer of the day had personally telephoned the nearest community hospital and was told the community hospital did not have the necessary imaging equipment to assess for an upper extremity DVT. The medical officer of the day further stated that the paramedic “acknowledged what I had said; they [the paramedic] heard me.”

The paramedic’s documentation acknowledged that the medical officer of the day evaluated the patient and believed the patient could have had a possible DVT. The paramedic documented that the medical officer of the day stated the patient should be transported to a community hospital emergency department, but that the paramedic “advised” the medical officer of the day that the nearest community hospital emergency department had been contacted and had accepted the patient.

The paramedic returned to the nearest community hospital emergency department and transported the patient from there to the community hospital advised by the medical officer of the day. Following imaging of the right upper extremity at the community hospital emergency department, the community provider diagnosed the patient with a hematoma, and the patient returned to the facility.<sup>38</sup>

## **Patient 4 (Alleged Communication Issues and Alleged Quality of Care Concerns)**

In late summer 2018, a patient in their early sixties saw the Urgent Care Center provider about a painful lump on the left buttock. The provider performed an incision and drainage on the perianal abscess.<sup>39</sup>

Two days later, the patient presented to the primary care clinic with complaints of dizziness, low blood pressure, and a worsening of the perianal abscess. The providers initially recommended transfer to another VA medical center for further treatment but reconsidered the transfer location

---

<sup>38</sup> A hematoma is a mass of usually clotted blood that forms in a tissue, organ, or body space as a result of a broken blood vessel. <https://www.merriam-webster.com/dictionary/hematoma>. (The website was accessed on August 26, 2019.)

<sup>39</sup> Incision and drainage are part of wound care and can be done as an in-office procedure. Perianal (anorectal) abscess is a collection of pus in or near the anus and rectum. <https://www.merckmanuals.com/roffessional/gastrointestinaldisorders/anorectal-disorders/anorectal-abscess>. (The website was accessed on May 14, 2019.)

because the patient was “hypotensive and tachycardic,” and felt that the patient should be taken to a closer community hospital for emergency evaluation and surgical consultation.<sup>40</sup> The patient was transported to a community hospital.

## **Patient 5 (Alleged EMTALA Violations and Alleged Quality of Care Concerns)**

In late summer 2018, during a primary care clinic appointment, a patient in their early sixties reported not feeling well and complained of right upper and lower quadrant abdominal discomfort, loss of appetite, and reduced bowel function. The patient indicated feeling constipated to the provider. The patient’s medical history included a gallstone, surgical repair of an inguinal hernia, and an abdominal aortic aneurysm.<sup>41</sup>

The physical exam revealed tenderness in the right upper and lower abdominal quadrants, no distention, rebound tenderness or signs of peritonitis.<sup>42</sup> The provider recommended that the patient go to the nearest emergency department for testing to rule out inflammation of the appendix or gallbladder and any vessel leakage.<sup>43</sup> The paramedic responded to the call and after an evaluation, transported the patient to the nearest community hospital emergency department as instructed.

The patient returned to the primary care clinic for an appointment about a week later and reported no longer being constipated. The patient noted that although the pain had improved overall, the back and abdominal pain continued intermittently. The patient requested gallbladder removal. A surgeon at another VA medical center evaluated the patient for gallbladder surgery approximately 10 days later, and surgery was scheduled for early 2019.

---

<sup>40</sup> Hypotensive is characterized as causing low blood pressure. <https://www.merriam-webster.com/dictionary/hypotensive> (The website was accessed on June 17, 2019.) Tachycardia is a rapid heart rate. <https://www.merriam-webster.com/dictionary/tachycardia>. (The website was accessed on June 17, 2019.)

<sup>41</sup> An inguinal hernia is a hernia in which part of the intestine protrudes into the inguinal canal. <https://www.merriam-webster.com/medical/inguinal%20hernia>. (The website was accessed on June 13, 2019.) Abdominal aortic aneurysm as an abnormal blood-filled bulge of a blood vessel and especially an artery resulting from weakening of the vessel wall. <https://my.clevelandclinic.org/health/diseases/7153-aorta-abdominal-aortic-aneurysm>. (The website was accessed on November 4, 2019.)

<sup>42</sup> Peritonitis is the inflammation of the smooth transparent serous membrane that lines the cavity of the abdomen. <https://www.merriam-webster.com/dictionary/peritonitis>. (The website was accessed on June 13, 2019.)

<sup>43</sup> The gallbladder is a membranous muscular sac in which bile from the liver is stored. <https://www.merriam-webster.com/dictionary/gallbladder>. (The website was accessed on June 13, 2019.) The appendix is “a small pouch that hangs from the large intestine where the small and large intestine join.” <https://www.facs.org/education/patient-education>. (The website was accessed on June 13, 2019.)

## Patient 6 (Alleged Quality of Care Concerns)

In late fall 2018, a cardiologist evaluated a patient in their early eighties for tiredness, shortness of breath, and occasional chest pressure occurring over the last few weeks. The patient's chest pain had characteristics of angina, and the cardiologist recommended an inpatient evaluation for chest discomfort.

The paramedic documented that the patient had a pulse of 56, a normal sinus rhythm, and

Dispatched to unknown cardiac on 4<sup>th</sup> floor in building 76. Upon arrival there was a delay to find Pt. [patient] due to miss communication [sic]. Pt [patient] was sitting in waiting room in no apparent distress.<sup>44</sup>

The paramedic evaluated and transported the patient to the agreed upon community hospital.

## Patient 7 (Alleged Quality of Care Concerns)

During a primary care clinic appointment for a pre-operative evaluation in early winter 2016, a patient in their early seventies had an EKG that revealed new-onset atrial fibrillation and inferior infarct of indeterminate age.<sup>45</sup> The patient denied any chest pain, shortness of breath, or cardiac history, and the physical exam was unremarkable. The provider decided to send the patient to a community hospital for evaluation and to rule out a myocardial infarct.<sup>46</sup> The paramedics arrived at the clinic, evaluated the patient, and transported the patient to a community hospital.

## Patient 8 (Alleged Quality of Care Concerns)

In spring 2019, during a visit to the primary care clinic, a patient in their early seventies was noted to have a heart rate of 190 beats per minute. The primary care provider determined that the patient needed a higher level of care. The paramedic arrived on scene within four minutes of being called, evaluated the patient, consulted with the provider, received medication orders, and obtained the medications prior to transporting the patient to a community hospital emergency department.

---

<sup>44</sup> A normal sinus rhythm is when the electrical impulses produced in the sinus node which contract the heart muscle and pumps blood into the lower chambers of the heart. The paramedic documented the provided location of the patient.

<sup>45</sup> According to the American Heart Association, atrial fibrillation is an irregular or quivering heartbeat that can lead to heart-related complications including heart failure, blood clots, and stroke.

<sup>46</sup> A myocardial infarct, also referred to as a heart attack, is commonly caused by an obstruction of arteries. Matthew J. Warner and Vijai S. Tivakaran, "Myocardial Infarction, Inferior" *StatPearls – NCBI Bookshelf*, January 11, 2019.

## Patient 9 (Alleged Quality of Care Concerns)

In spring 2019, a patient in their early sixties with end-stage chronic obstructive pulmonary disease was seen in the Urgent Care Center with complaints of worsening shortness of breath. The patient initially improved after three nebulizer treatments and a steroid dose but worsened with minimal activity.<sup>47</sup> After consulting respiratory therapy, the provider administered a fourth nebulizer treatment to the patient, but there was no improvement. At that time, the provider noted elevated respiratory and heart rates. The provider determined the patient was decompensating and going into respiratory failure. The provider called the community hospital emergency department to arrange transfer.

Upon arrival, the paramedics evaluated the patient and discussed the use of epinephrine with the provider, but the provider declined.<sup>48</sup> The paramedic placed a non-rebreather oxygen mask on the patient and transported the patient.<sup>49</sup>

## Patient 10 (Alleged Quality of Care Concerns)

In spring 2019, during a routine follow-up appointment in the primary care clinic, a patient in their mid-seventies had laboratory results that identified severe anemia and a possible gastrointestinal bleed. The paramedics responded to the call, evaluated the patient, conferred with the medical control officer, and transported the patient to the agreed upon community hospital.

## Patient 11 (Alleged Quality of Care Concerns)

A patient in their mid-fifties presented to the primary care clinic for an unscheduled visit in spring 2019, with complaints of intermittent jaw pain when eating, nausea, pain in the left rib cage, shortness of breath, migraines, and tension headaches. The provider obtained an EKG.

---

<sup>47</sup> A nebulizer treatment involves turning liquid medicine into a mist which a patient then inhales. <https://my.clevelandclinic.org/health/treatments/4297-home-nebulizer-therapy>. (The website was accessed on July 17, 2019.) Steroids are a type of medication that works by decreasing inflammation in the body and reduces activity in the immune system. <https://my.clevelandclinic.org/health/drugs/4812-corticosteroids>. (The website was accessed on July 17, 2019.)

<sup>48</sup> Epinephrine is a medication used to stimulate a person's heart during cardiac arrest or to treat a life-threatening allergic reaction. <https://www.merriam-webster.com/dictionary/epinephrine>. (The website was accessed June 17, 2019.) For this event, epinephrine would have been used to open the patient's main airway passages to their lungs. [https://www.clinicalkey.com/nursing/#!/content/patient\\_handout/5-s2.0-pe\\_afdb607e-2e8f-4aa9-aae3-94fd71a98598](https://www.clinicalkey.com/nursing/#!/content/patient_handout/5-s2.0-pe_afdb607e-2e8f-4aa9-aae3-94fd71a98598). (The website was accessed on October 30, 2019.)

<sup>49</sup> A non-rebreather mask delivers a high concentration of oxygen by preventing both room air and exhaled air from mixing with the oxygen. <https://accessemergencymedicine.mhmedical.com/content.aspx?sectionid=201305148&bookid=2498&jumpsectionid=206690446&Resultclick=2>. (The website was accessed on June 11, 2019.)

The paramedics were called to transport the patient to a community hospital's emergency department. The paramedic assessed the patient, placed the patient on a cardiac monitor, noted normal cardiac rhythm, and transported the patient to a community hospital emergency department. The paramedic monitored and documented the patient as stable throughout the transport.

The community hospital evaluated the patient, completed a cardiac workup, and discharged the patient home with a diagnosis of unspecified chest pain.

## **Patient 12 (Alleged Quality of Care Concerns)**

A patient in their early sixties was an inpatient in the domiciliary at the facility. In late summer 2018, the patient had an elevated blood pressure, but no complaints of chest pain, shortness of breath, dizziness, or palpitations. After consulting the Urgent Care Center provider, the domiciliary nursing staff contacted the paramedics for transport. The paramedics evaluated the patient, explained the risks of high blood pressure, and noted that the patient was very anxious.

Although the patient agreed to transfer to a community hospital, the patient would not agree to being secured to the stretcher. The paramedic documented that

I consulted the MOD [medical officer of the day] via cell phone for a possible treatment for [the patient's] anxiety. I advised the MOD that the only sedative I had on hand was Versed™ [midazolam].<sup>50</sup> The MOD stated that Versed™ would be [sic] ineffective due to its short half-life. We collectively agreed to allow the pt [patient] to travel in a position of comfort and to monitor [their] vital signs as possible.

The patient agreed to sit in the captain's chair with a seatbelt fastened for transport.<sup>51</sup>

## **Patient 13 (Alleged Quality of Care Concerns)**

A patient in their mid-sixties made two suicide attempts in late summer 2018, during a stay on the facility's short-term rehabilitation unit.<sup>52</sup> The patient was placed on one-to-one observation and transferred to the acute care inpatient unit. A facility psychiatrist evaluated the patient and

---

<sup>50</sup> Midazolam is a sedative that may decrease anxiety and induce relaxation before medical procedures. <https://my.clevelandclinic.org/health/drugs/19616-midazolam-injection>. (The website was accessed on November 4, 2019.)

<sup>51</sup> In an ambulance, the captain's chair is located either midpoint for easy reach of necessary equipment or at the head in order to have the best access to maintain the airway of a patient on the stretcher. <https://www.fireapparatusmagazine.com/articles/print/volume-22/issue-11/features/ambulance-designs-evolving-to-meet-specific-customer-needs.html>. (The website was accessed on May 9, 2019.)

<sup>52</sup> Nursing staff discovered the patient at approximately 5:00 a.m. in the patient's room with scratches to the wrist and femoral area, minor bleeding, and with a telephone cord wrapped around the patient's neck.

recommended “transfer on [an] involuntary status to locked psychiatric unit for further stabilization.” The medical officer of the day documented the need for four-point restraints during transfer to a locked unit. The medical officer of the day reported that no other local VA medical centers had psychiatric beds and recommended utilizing a non-VA inpatient psychiatric facility. Although the patient had complex medical conditions, the patient was considered medically stable for transport. Nursing staff continued to monitor the patient while waiting for a psychiatric bed. Approximately 12 hours later, two nursing staff members escorted the restrained patient to a community psychiatric facility in an ambulance.<sup>53</sup>

---

<sup>53</sup> Nursing staff escorted the patient to a community hospital at 4:48 p.m.

## Appendix B: VISN Director Memorandum

### Department of Veterans Affairs Memorandum

Date: December 3, 2019

From: Director, New York/New Jersey VA Health Care Network (10N02)

Subj: Healthcare Inspection—A Delay in Patient Notification of Test Results and Other Communication Issues at the Bath VA Medical Center, New York

To: Director, Office of Healthcare Inspections, (54HL08)  
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. Thank you for the opportunity to review the OIG report, Healthcare Inspection—A Delay in Patient Notification of Test Results and Other Communication Issues at the Bath VA Medical Center, New York. I concur with the report findings and recommendations.
2. If any additional information is needed, please do not hesitate to contact Pam Wright, VISN2 QMO.

*(Original signed by:)*

Joan E. McInerney, MD, MBA, MA, FACEP  
Network Director, VISN 2

## Appendix C: Facility Director Memorandum

### Department of Veterans Affairs Memorandum

Date: November 29, 2019

From: Director, Bath VA Medical Center (528A5/00)

Subj: Healthcare Inspection—A Delay in Patient Notification of Test Results and Other Communication Issues at the Bath VA Medical Center, New York

To: Director, New York/New Jersey VA Health Care Network, (10N2)

I have reviewed the draft report of a delay in patient notification of test results and other communication issues from the Office of Inspector General (OIG) and I concur with the recommendations 1-2 from the focused review on April 8th. The VA Finger Lakes Healthcare System (Bath and Canandaigua VAMCs), has developed action plans to address the recommendations which are included in the attached comments.

I would like to thank the OIG Survey Team for the consultative visit. The recommendations will strengthen our processes to deliver consistent quality care to our Veterans.

Please contact me if you have additional questions or comments.

*(Original signed by:)*

Bruce Tucker, LCSW-R  
Medical Center Director



## Facility Director Response

### Recommendation 1

The Bath VA Medical Center Director ensures that surrogate providers comply with the facility's notification policy when providing coverage.

Concur

Target date for completion: July 2020

### Director Comments

In December 2017, the facility revised its notification of test results policy to include specific and timely notification of stress tests and echocardiograms. The Bath VA will enhance the current process with an integrated VA Finger Lakes Healthcare System standard operating procedure for surrogate assignment and responsibilities. The Acting Chief of Staff will ensure compliance via manual data pulls until at least 90 percent compliance is sustained for 4 months after the standard operating procedure has been revised with reports to the Executive Committee of Medical Staff.

### Recommendation 2

The Bath VA Medical Center Director ensures that the Bath VA Medical Center Patient Transfer Policy clearly defines a process for outpatient transfers to a higher level of care utilizing facility paramedics.

Concur

Target date for completion: July 2020

### Director Comments

In April 2019, the facility revised its Patient Transfer Policy specific to paramedic involvement in transfers. The facility will further integrate the existing Bath and Canandaigua VAMC transfer policies to a VA Finger Lakes Healthcare System policy that includes clear direction for patient transfer to a higher level of care. The Acting Chief of Staff will ensure compliance via a comprehensive review of transfers until at least 90 percent compliance is sustained for 4 months after the policy has been revised with reports to the Executive Committee of Medical Staff.

## OIG Contact and Staff Acknowledgments

---

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

---

<b>Inspection Team</b>	Joanne Wasko, MSW, LCSW, Director Elaine Aubin, BSN W. Iris Barber, JD Amanda Barry, MSW Thomas Jamieson, MD Martha Kearns, MSN, FNP-C Valerie Lumm, MHA, RN
------------------------	--

---

<b>Other Contributors</b>	Josephine Andrion, MHA, RN Felicia Burke, MS Shirley Carlile, BA Natalie Sadow, MBA
---------------------------	--

## Report Distribution

### VA Distribution

Office of the Secretary  
Veterans Health Administration  
Assistant Secretaries  
General Counsel  
Director, New York/New Jersey VA Health Care Network (10N02)  
Interim Director, VA Finger Lakes Health Care System (528/00)

### Non-VA Distribution

House Committee on Veterans' Affairs  
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and  
Related Agencies  
House Committee on Oversight and 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: Charles E. Schumer, Kirsten E Gillibrand  
U.S. House of Representatives: Anthony Brindisi, John Katko, Joseph Morelle,  
Tom Reed II

*The OIG has federal oversight authority to review the programs and operations of VA medical facilities. OIG inspectors review available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leadership on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.*

**OIG reports are available at [www.va.gov/oig](http://www.va.gov/oig).**