



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 15-00347-154

Healthcare Inspection

Alleged Lack of Timeliness and Quality of Care Concerns at the Memphis VA Medical Center Memphis, Tennessee

April 16, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:

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Executive Summary

The VA Office of Inspector General (OIG) conducted an inspection in response to complaints about the timeliness and quality of care in the Emergency Department (ED) and Primary Care of the Memphis VA Medical Center (facility), Memphis, TN, which is part of Veterans Integrated Service Network 9.

We did not substantiate the allegation that Memphis ED personnel were inattentive and failed to provide timely care. The patient was triaged appropriately on arrival. The 4-hour delay the patient experienced before leaving without being seen by an ED provider was unfortunate yet unavoidable due to the patient population in the ED at the time of the patient's visit.

We did not substantiate the allegation that Primary Care provider assistants were inattentive to the patient's requests for medical help via phone and VA's electronic secure messaging system. Primary Care clinic staff responded to the patient's requests, and the patient received the services he requested. While we found occasional delays in responding to the patient's requests, overall, delays were not typical.

We substantiated the allegation that VA refused to pay for private facility care; however, this decision was based on Federal regulations.

We substantiated the allegation that the facility faxed incorrect records to the ED of a private hospital. This was attributed to human error by a staff member at the facility, and as a result, the facility changed its process for providing medical information to other hospitals. We found that the new process was being followed at the time of our visit; therefore, we made no recommendation.

We did not substantiate the allegation that the facility ignored recommendations or postponed implementation of actions recommended by the OIG in previous reports. The facility has made strides in improving both the physical layout and processes in the ED. These changes are reflected in data for patient length of stay and time from arrival to treatment.

We made no recommendations.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the report. (See Appendixes A and B, pages 8–9 for the Directors' comment.) No further action is required.



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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by a complainant regarding the timeliness and quality of care in the Emergency Department (ED) and Primary Care (PC) at the Memphis VA Medical Center (facility), Memphis, TN.

Background

The facility is part of Veterans Integrated Service Network 9. It provides acute medical and surgical care, as well as a full range of primary, specialty, and subspecialty services, with a 22-bed ED and 244 operating inpatient beds.

In October 2014, the OIG Office of Healthcare Inspections received a complaint of lack of timeliness and poor quality of care at the facility. Specifically, the allegations stated that:

- Facility ED personnel were inattentive and failed to provide timely care when a patient presented to the ED.
- PC provider assistants were inattentive to requests for medical help.
- The facility refused to pay for care received at a private hospital when the patient was taken by ambulance to a private hospital because the facility was on diversion.
- ED personnel faxed incorrect medical records to a private hospital's ED.
- The facility ignored recommendations or postponed implementation of actions recommended by the OIG in previous reports.

Scope and Methodology

We conducted a site visit November 3–7, 2014. We interviewed the facility Director, the ED nurse manager, and the ED Director. We reviewed electronic health records, relevant policies, documents, and data. We also interviewed the patient.

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

Inspection Results

Case Review

The patient is a man in his seventies with a history of benign prostatic hypertrophy, thyroidectomy for cancer, and degenerative arthritis. According to Emergency Department Integration Software¹ (EDIS) and electronic health record documentation, he was evaluated in the facility's ED for symptoms of a urinary tract infection in spring 2014. He presented to the ED in the morning and was seen 18 minutes later by the triage nurse. His vital signs were assessed to be stable, and the nurse assigned an emergency severity index² (ESI) level of 4. One hour and 15 minutes after triage, an ED provider evaluated the patient and ordered medication to treat the urinary tract infection. The patient was discharged a little over 3 hours after presentation.

The patient returned to the ED 2 days later with worsening symptoms. He presented in the mid-afternoon and was seen by the triage nurse 38 minutes later. At that time, he had a normal blood pressure and low grade fever (temperature 100.3 degrees Fahrenheit). His previous visit to the ED and current symptoms were noted, and an ESI level of 3 was assigned. In the evening, about 4 hours after being triaged, the patient informed the nurse that he could not wait any longer, and left the ED before being seen for further evaluation by a medical provider.

Approximately 10 hours after leaving the ED, the patient was taken by ambulance to a private hospital after emergency medical services (EMS) personnel were reportedly told that the facility was on diversion. At the private hospital, the patient described chest pain, near-syncope,³ and shaking chills and was noted to have a temperature of 103.1 degrees Fahrenheit. He was admitted, treated with intravenous antibiotics, and discharged much improved after 5 days. Eighteen days later, the patient was evaluated in the facility urology clinic, and prostate surgery was planned after completion of an extended course of oral antibiotic treatment. Seven weeks after that urology evaluation, the patient underwent transurethral resection of the prostate, and 3 months after surgery he reported significant improvement in his urinary symptoms.

Inspection Results

Issue 1: ED Care

We did not substantiate the allegation that Memphis ED personnel were inattentive and failed to provide timely care when a patient presented to the ED.

¹ Emergency Department Integration Software (EDIS) is used to track patient activity in Veterans Health Administration Emergency Departments and urgent care clinics.

² ESI is a five-level algorithm that categorizes acuity and expected resource needs into five groups from 1 (requires immediate, life-saving intervention) to 5 (non-urgent) and assists with patient management decisions.

³ Near-syncope is the sensation that fainting is imminent, but complete loss of consciousness does not occur.

Veterans Health Administration (VHA) requires that a registered nurse triage all patients who present to the ED and assign an acuity level based on the ESI. Triage is the process of early assessment of patients to ensure that they receive appropriate attention with the requisite degree of urgency.

VHA further requires that facilities comply with the Emergency Medical Treatment and Labor Act (EMTALA) of 1986.⁴ EMTALA requires hospitals that offer emergency services to provide a medical screening examination and necessary stabilizing treatment when a request is made for examination or treatment before transferring the patient to another facility.

The patient stated that because he was in immediate need of medical attention, and the VA ED was full at the time of his second ED visit, he should have been directed to a private sector hospital to receive urgently needed medical care. However, directing the patient elsewhere without a proper screening and stabilizing treatment would have been a violation of the EMTALA. The patient was triaged appropriately based on presenting symptoms and vital signs. Patients are seen by medical need and ESI scores, and delays are often unavoidable depending on the unpredictable number and needs of patients in an ED. Review of ED data at the time the patient presented to the ED showed that the ED was full and that 30 minutes prior to the patient's arrival to the ED four patients with level 2 ESI ratings (high risk) had been admitted. In addition, there were four other patients in the ED who required ongoing 1-to-1 care (one nurse assigned to one patient).

Issue 2: Delays in Access to Primary and Specialty Care

We did not substantiate the allegation that PC provider assistants were inattentive to requests for medical help.

VA has introduced secure messaging as a method of communication between patients and their providers through My HealthVet.com, the VA's online personal health record. The facility's goal is to respond to secure online messages within 72 hours.

The patient stated that it took too long, sometimes up to 5 working days, to receive a reply when he requested services via secure messaging. The patient also said that despite facility claims that a restriction for scheduling appointments beyond 90 days had been lifted, the restriction was still in place when he tried to schedule an appointment with a specialty clinic.

According to the electronic health record and documents provided by the patient, he contacted the facility urology clinic by phone requesting an appointment. The patient was appropriately referred to his PC provider since he had not been seen in the urology clinic for over a year. The patient then contacted his PC clinic by phone. The PC clinic

⁴ In 1986 Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay.

staff returned his phone call the next day. A consult was placed the same day, and the patient was seen in the urology clinic within 13 working days.

The patient requested an appointment with Orthopedic Services through secure messaging in spring 2014. PC clinic staff responded 2 days later that his request would be discussed with his PC provider and offered to schedule him into the PC clinic if needed. The patient responded back to the message from the clinic staff the same day and informed them that he had been seen in a private clinic and had an appointment scheduled with a private orthopedist in 4 days but still wanted to be seen by a VA orthopedist. The patient sent another message 4 days later with a second request for an appointment with Orthopedic Services. A PC clinic staff member replied to this message the next day and noted that the patient had been seen by a private orthopedist. The staff member sent a message to the patient 2 days after the last one, asking if there was anything that they could do for the patient. The patient replied to the message and made a third request for an orthopedic appointment. PC staff responded 5 days later and instructed the patient to get x-rays and informed him that the consult would be placed when the results were available. A consult to Orthopedic Services was placed 30 days after the patient's initial request, and the patient was seen by Orthopedic Services 33 days later.

In winter 2014, the patient requested an appointment for 6 months in the future in a specialty clinic. The patient was reportedly told that appointments could not be made more than 90 days in advance. In response to an inquiry to the Director by the patient on this policy, the facility Director responded that in May 2014 the policy had been changed to allow scheduling of appointments more than 90 days in the future. When the patient requested an appointment with the same clinic in June 2014, the clinic clerk told him "no" when asked if he could schedule an appointment for more than 90 days in the future. Facility-wide training on the new appointment scheduling computer templates and guidelines began in May 2014 and was completed by July 2014. The staff in the clinic in question had not been trained yet at the time of the patient's request. While onsite we confirmed that appointments were available up to 365 days out in the current scheduling system.

Issue 3: Refusal To Pay for Private Facility Care

We substantiated the allegation that VA refused to pay for private facility care; however, this decision was based on Federal regulations.

Several hours after the patient left the facility ED without being seen (as discussed under issue 1), he had a near syncopal episode and was transported from his home to a private facility by ambulance. The emergency medical system provider in attendance documented that, "When contacting [Memphis] VA Medical Center Memphis, TN to give report was advised by ER nurse to divert to Methodist University Memphis, TN." We confirmed that the facility was on diversion from 12:50 a.m. until 6:00 a.m.

VHA policy for diversion of patients to another hospital states that a facility can divert patients from the ED to other facilities only if certain conditions exist and appropriate

care, services, or beds are not available.⁵ Diversion applies only to patients being transported by ambulance and does not include walk-in patients. The policy further states that if a patient demands to go to a VA facility that is on diversion, the request must be honored unless complying with the patient's request could result in further harm to the patient from a delay in obtaining appropriate treatment.

At the direction of the patient, the private hospital billed the facility for the patient's care. The facility denied payment and sent the patient a letter explaining the terms in which the facility would pay for care in the private sector. The denial letter sent to the patient essentially mirrored the eligibility requirements outlined by VA regulations and explained as follows: (1) the veteran is financially liable to the provider for emergency treatment, (2) the veteran is enrolled in the VA health care system and received treatment within the 24-month period preceding the emergency treatment, (3) the veteran is personally liable for emergency treatment and has no other coverage under a health plan contract, (4) VA facilities are not feasibly available and an attempt to use them beforehand would have been hazardous to life or health, and (5) emergency services were provided in a hospital ED up to the point of medical stability.

Because the patient had other, non-VA medical coverage (insurance) and did not meet all of the criteria set by Federal regulations, the facility declined to pay for the private care.

Issue 4: Provision of Incorrect Medical Information

We substantiated the allegation that the facility faxed incorrect records to the ED of a private hospital.

An outdated (2008), inaccurate list of the patient's medications was faxed to a private hospital from the facility ED. This was discovered by the patient when nursing personnel at the private hospital attempted to reconcile the differences between what the patient told them he was taking with the medication list provided by the facility.

Prior to our site visit, the facility determined that provision of an incorrect list of medications by fax was human error and instituted a process of a second staff member taking "one last look" at documents being faxed to another facility for verification that they are correct.

Issue 5: Implementation of Actions Recommended by the OIG

We did not substantiate the allegation that the facility ignored recommendations or postponed implementation of actions recommended by the OIG in previous reports.

OIG Report No. 11-04090-253, *Emergency Department Delays, Memphis VA Medical Center, Memphis, TN*, published August 15, 2012, recommended that appropriate actions be taken to reduce ED length of stay, that ultrasound services for ED patients

⁵ VHA Medical Facility Emergency Department Diversion Policy, 2009-069, December 16, 2009.

are readily available by in-house or on-call staff 24 hours a day, and that data entered in EDIS related to ED visits be accurate. To improve length of stay times: (1) nurse staffing has been increased in the ED; (2) two evening shift supervisors have been added; (3) a pneumatic tube system between the ED and the laboratory was installed to reduce wait times for lab results; and (4) processes have been changed to improve patient flow, admit patients faster, and reduce ED crowding. Measures have been taken to improve turnaround time for ultrasound test results. Furthermore, at the time of our visit, EDIS data accuracy was much improved and showed that from October 2013 through October 2014, patient length of stay in the ED and door to triage times⁶ were at or better than VHA national trends. Steady improvement was also noted in reduction of admission delays.

OIG Report No. 11-04090-253, *Emergency Department Patient Deaths, Memphis VA Medical Center, Memphis, Tennessee*, published October 23, 2013, recommended that patients be appropriately monitored in all ED rooms and unit-specific competency assessments be completed for ED nursing staff. During the site visit, we found that all ED beds now have central monitoring capabilities⁷ with multiple screens strategically placed throughout the ED displaying patient vital signs and heart rhythms. Structural changes have been made to improve patient flow and visibility in the triage area and main ED, and construction has begun on a new ED. A comprehensive education program for the nursing staff was implemented, including annual and as needed ED-specific unit competency validations and multiple educational opportunities specific to the patient population of an ED.

Conclusions

We did not substantiate the allegation that Memphis ED personnel were inattentive and failed to provide timely care. The patient was triaged appropriately on arrival. The 4-hour delay the patient experienced before leaving without being seen by an ED provider was unfortunate yet unavoidable due to the patient population in the ED at the time of the patient's visit.

We did not substantiate the allegation that PC provider assistants were inattentive to requests for medical help, and the facility prevented veterans from receiving requested medical care. PC clinic staff responded to the patient's requests, and the patient received all requested services. There was one 5-day delay in answering the patient's requests submitted through MyHealthVet; however, delays were not typical overall for this patient.

We substantiated the allegation that VA refused to pay for private facility care; however, this decision was based on Federal regulations.

⁶ Door to triage times is the amount of time from when the patient arrives in the ED to when they are first seen by a health care provider.

⁷ Patient vital signs and heart rhythm are displayed on a screen at the patient's bedside and are also displayed on screens around the nurse's station and other locations.

We substantiated the allegation that the facility faxed incorrect records to the ED of a private hospital. This was attributed to human error. The facility had identified the problem and taken action to improve the process of providing medical information to other facilities. The improved process was being followed at the time of our visit, so no recommendation was made.

We did not substantiate the allegation that the facility ignored recommendations or postponed implementation of actions recommended by the OIG in previous reports. The facility has improved both the physical layout and processes in the ED. The improvements are reflected in EDIS data for patient length of stay and time from arrival to treatment from May 2013 to October 2014.

We made no recommendations.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: February 17, 2015

From: Director, VA Mid South Healthcare Network (10N9)

Subj: Healthcare Inspection—Alleged Lack of Timeliness and Quality of Care Concerns, Memphis VA Medical Center, Memphis, Tennessee

To: Director, Bay Pines Office of Healthcare Inspections (54SP)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. I have reviewed the draft report of the Healthcare Inspection—Alleged Lack of Timeliness and Quality of Care Concerns conducted November 3-7, 2014. There were no recommendations and I concur with the findings in the report.
2. If you have any questions, contact Cynthia Johnson, VISN 9 Quality Management Officer at (615) 695-2206 or Joseph Schoeck, VISN 9 HSS at (615) 695-2205.

(original signed by:)
Jim Hayes for John Patrick, Director

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: February 6, 2015

From: Director, Memphis VA Medical Center (614/00)

Subj: Healthcare Inspection—Alleged Lack of Timeliness and Quality of Care Concerns, Memphis VA Medical Center, Memphis, Tennessee

To: Director, VA Mid South Healthcare Network (10N9)

1. I have reviewed the draft report of the Healthcare Inspection—Alleged Lack of Timeliness and Quality of Care Concerns conducted November 3-7, 2014. I acknowledge there were no recommendations and concur with the findings in the report.

2. If you have future questions, please contact Jan Slate, Accreditation Manager, Quality Management and Performance Improvement. Mrs. Slate can be reached at (901) 677-7379, menu choice # 5.

(original signed by:)

C. Diane Knight, M.D., Director

OIG Contact and Staff Acknowledgments

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