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Deficiencies in Echocardiogram Interpretation Timeliness, Facility Policies, Patient Safety Reporting, and Oversight at the Fayetteville VA Coastal Health Care System in North Carolina

Healthcare Inspection | 22-01230-185 | August 30, 2023

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Fayetteville VA Coastal Health Care System (facility) in North Carolina, to assess an allegation that the chief of medicine "forced" a hospitalist to admit a patient who needed services that were unavailable at the facility.[1] The OIG also evaluated reported concerns regarding limited inpatient specialty services, hospitalists' coverage, and peer review processes.[2] During the inspection, the OIG identified that the facility's intensive care unit (ICU) standard operating procedure (SOP) and policy permitted admission of patients requiring continuous renal replacement therapy (CRRT), despite the facility not having resources available to support the treatment.[3] The OIG also identified delays in echocardiogram interpretation times, deficiencies in patient safety reporting practices, and noncompliance with privileging and evaluating intensivists.[4]

Admission of Patients with Limited Inpatient Specialty Services

The OIG did not substantiate that the chief of medicine forced a hospitalist to admit a patient who needed services that were unavailable at the facility.

The OIG reviewed the identified patient's electronic health record.

> *In early winter 2021, a patient presented to the emergency department with one week of worsening chest pain with exertion and shortness of breath. The electrocardiogram (EKG) showed a possible myocardial infarction, however, the*

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[1] Hospitalists are physicians and advanced practice providers (physician assistants and nurse practitioners) who "typically undergo residency training in general internal medicine. . . or family practice." Hospitalists provide hospital-based care, Society of Hospital Medicine, "What is hospital medicine, and what is a hospitalist?" accessed on March 23, 2022, https://www.hospitalmedicine.org/about/what-is-a-hospitalist/.

[2] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. Peer review is a confidential process used to review the clinical care provided by individual healthcare providers.

[3] Facility SOP 11-10, *Adult Intensive Care Unit (ICU) Admission, Triage and Discharge Standard Operating Procedure*, January 1, 2022; Facility Policy 11-40, *Adult Intensive Care Unit, (ICU) Admission, Triage and Discharge*, January 1, 2022; University of Maryland Baltimore Washington Medical Center, "Continuous Renal Replacement Therapy," accessed October 27, 2022, https://www.umms.org/bwmc/health-services/inpatient/patient-education/continuous-renal-replacement-therapy. Continuous renal replacement therapy is a continuous slow motion dialysis treatment that runs 24 hours a day and is used in ICUs to treat patients whose kidneys are not functioning properly.

[4] Echocardiogram interpretation time elapsed in days is the time from the echocardiogram order to the result being available. VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. This handbook was in effect at the time of the events discussed in this report and was rescinded and replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021, and 1100.21 (1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA Handbook 1100.19 and VHA Directive 1100.21 (1) contain the same or similar language related to the definition of privileging. Privileging refers to the process of approving a provider to perform certain procedures and services in a specific facility; The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

patient's troponin tests, a blood test to aid in diagnosis of a myocardial infarction, were negative. An emergency department provider recommended admission to rule out acute coronary syndrome for ongoing chest pain. A hospitalist documented "I don't think it would be safe for the patient to be admitted here [facility] unless [cardiology service has] been consulted and agreed." After the emergency department provider told the hospitalist that the on-call facility cardiologist was not available, the hospitalist recommended transferring the patient to a facility with a cardiologist who could evaluate the patient. An intensivist contacted the chief of medicine to determine a decision on the patient's admission. Following the discussion with the intensivist, the chief of medicine requested the hospitalist admit the patient, however, after communicating via electronic messaging with the hospitalist, the chief of medicine recommended contacting a cardiologist at another VA medical center.

The patient was subsequently transferred to another VA medical center and received cardiology and pulmonary services.

Facility policy indicates that emergency department providers directly contact hospitalists to request an inpatient admission.[5] Further, the policy notes that the requesting provider and hospitalist then "jointly decide as to the appropriateness and type of admission."[6] Lastly, the policy indicates that "the [c]hief [h]ospitalist will be available to resolve disagreements" related to admission decisions.[7] Facility policy requires patients who need services that are not available at the facility "be transferred to another facility in an expeditious manner."[8]

Hospitalists are responsible for the initial assessment of patients, to include completion of a history and physical examination, determination of diagnoses, and creation of a treatment plan. As needed, hospitalists consult with specialty and other clinical services and incorporate the resulting information into patients' diagnoses and treatment plans.[9]

The OIG concluded the hospitalists and emergency department providers followed policy, which included making a joint decision regarding the patient's admission, and that the chief of medicine assisted with the resolution of providers' differing opinions regarding the admission

[5] Facility MCP 00-43, *Hospitalist Program,* September 21, 2021.

[6] Facility MCP 00-43.

[7] Facility MCP 00-43. The chief hospitalist supervises hospitalists and other Hospitalist Section staff and oversees the functions of the Hospitalist Section of the Medical Service. A quality management staff member reported to the OIG that in February 2022, the chief hospitalist position was vacant, and the chief of medicine reported being the acting chief hospitalist.

[8] Facility MCP 11-16, *Patient Movement and Management*, February 28, 2020.

[9] Facility MCP 00-43.

decision in accordance with facility policy.[10] The OIG did not identify any adverse clinical outcomes associated with the identified patient's care.[11]

The OIG reviewed the availability of specialty services and found the facility had limited inpatient cardiology services available. At the time of the inspection, the facility had the least complex type of ICU (level 4) and was not required to have inpatient cardiology services.[12]

The Veterans Health Administration (VHA) provides guidance for subspecialty availability at facilities with an ICU. Basic services listed for a level 4 ICU include "core hours, or on-call support" for pharmacy services, "limited lab [laboratory] services" and "very limited subset of specialist and sub specialist by referral." Specialists and subspecialists who need to be available by referral are not defined.[13]

The OIG found, at the time of the inspection, the facility had one inpatient cardiologist who had worked virtually since late summer 2021. The chief of medicine was aware of hospitalists' concerns with admitting patients without having face-to-face inpatient cardiology consultation availability. In response to these concerns, the chief of medicine and the virtual inpatient cardiologist developed an SOP to assist hospitalists in determining when a cardiac admission was safe.[14]

While the facility did not have face-to-face inpatient cardiology consultation, virtual inpatient cardiology consultation was available. Further, the OIG determined that face-to-face inpatient cardiology consultation was not required, given the facility's level 4 ICU designation.

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[10] Facility MCP 00-43.

[11] Within the context of this report, the OIG considered an adverse clinical outcome to be death, a progression of disease, or worsening prognosis.

[12] "Invasive Procedure Complexity," VHA National Surgery Office, accessed June 24, 2022, https://dvagov.sharepoint.com/sites/VHANSO/SitePages/VA-Operative-Complexity-Designation.aspx; "FY20 Complexity Final Model Variables," VHA Office of Productivity, Efficiency and Staffing, accessed June 24, 2022, https://dvagov.sharepoint.com/:x:/r/sites/VHAOPES/_layouts/15/Doc.aspx?sourcedoc=%7B44337330-630E-4A69-A1B2-DD34FC0E3069%7D&file=4.%20FY20%20Complexity%20Final%20Model%20Variables.xlsx&action=default&mobileredirect=true&DefaultItemOpen=1&wdLOR=cB7959324-A81A-423E-8A54-E783D5449B21. (These websites are not publicly accessible.) The ICU level indicates the complexity of the ICU cases that can be handled by the hospital with ICU level 1 being the most complex and ICU level 4 being the least complex.

[13] According to a program manager for the VHA Office of Quality and Patient Safety, criteria for an ICU designation is included in a report issued in 2007 by the VHA Office of Healthcare Analysis and Information Group, which defines services provided in ICUs; Healthcare Analysis and Information Group, Office of the ADUSH for Policy and Planning, *VHA 2007 Survey of Intensive Care Units (ICUs) & Acute Inpatient Medical & Surgical Care in VHA*, November 2007, https://vaww.va.gov/HAIG/ICU/2007ICUAcuteInptMedSurgReport.pdf. This survey includes ICU level criteria and services provided for Basic, Moderate, and Complex designations. (This website is not publicly accessible.)

[14] Facility SOP 111-9, *Use of Cardiology Consultation Prior to Acceptance of Cardiac Admissions*, December 16, 2021.

VHA designates VA medical facilities that perform invasive procedures as either *inpatient standard*, *inpatient intermediate*, or *inpatient complex* and has established infrastructure requirements for each designation.[15] At the time of the inspection, the facility had an inpatient standard invasive procedure complexity (standard) designation.[16] "Inpatient standard invasive procedures are typically performed on a same day basis and require an ICU with the ability to provide hemodynamic monitoring and respiratory support of the patient recovering from general anesthesia; pharmacy and blood bank during weekday duty hours; an ED [emergency department] and a physician call schedule to support the invasive services provided."[17]

During the inspection, an emergency department physician and hospitalist reported that limited surgical services at the facility impacted their decisions on whether to admit or transfer patients who needed surgical services. The OIG reviewed 10 electronic health records (EHRs) of patients who needed surgical services.[18] The OIG determined that of the 10 patients, 1 declined surgery, 2 were managed at the facility, and 7 were transferred to non-VA facilities for surgical evaluation. The OIG did not identify any adverse clinical outcomes related to the 10 patents who needed surgical services.[19]

The OIG concluded the facility had limited inpatient surgical services and, consistent with VHA policy, patients with surgical needs that exceeded the facility's capabilities were transferred to another facility for evaluation and treatment.[20]

During the inspection, the OIG identified that the ICU SOP and policy permit admission of patients requiring CRRT, despite the facility not having resources available to support the treatment.[21]

The ICU SOP and policy state that "[p]atients requiring services not available at this facility will be referred to an appropriate facility."[22] Additionally, the ICU SOP and policy state, "Adult

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[15] VHA Directive 1220 (1). *Facility Procedure Complexity Designation Requirements To Perform Invasive Procedures in Any Clinical Setting,* February 11, 2020. VHA requires that diagnostic services including EKG, laboratory, plain film radiography, and radiology interpretation are available on-site weekdays and all other times on-call within 60 minutes.

[16] For standard complexity facilities, VHA requires that anesthesia, general medicine, and general surgery consultation is available on-site during weekdays, day shift, and all other times on-call within 15 minutes by phone and within 60 minutes on-site.

[17] VHA Directive 1220 (1).

[18] During the inspection, a total of 25 patients were identified by the complainant or by facility staff members as being potentially affected by limited inpatient specialty services at the facility. Fifteen of the 25 patients did not need surgical services.

[19] No adverse clinical outcomes were identified in any of the 25 patients reviewed by the OIG.

[20] VHA Directive 1220 (1).

[21] Facility SOP 11-10; Facility MCP 11-40.

[22] Facility SOP 11-10; Facility MCP 11-40.

critically ill patients with the following conditions may be admitted or transferred to the ICUs. . . [p]atients requiring CRRT."[23]

The OIG found that the facility did not have resources including equipment and trained nursing staff to provide CRRT. In an interview with the OIG, the chief of medicine acknowledged that "a patient with renal disease requiring renal replacement" would be transferred to an appropriate facility. A facility nephrologist reported the facility does not have the ability to perform CRRT in the ICU.

The OIG concluded the ICU SOP and policy are inconsistent with the facility's available resources to support the admission of patients requiring CRRT. If a patient were to be admitted with a condition requiring CRRT, the patient would require transfer to a facility capable of providing CRRT, potentially delaying treatment and risking patient harm.

Delays in Echocardiogram Interpretation

During the inspection, the OIG determined that inpatient echocardiograms were not interpreted timely. While neither VHA nor the facility define time frames for echocardiogram interpretation, the chief of medicine provided informal documentation to the OIG that indicated inpatient echocardiogram interpretation would occur within 24–48 hours. Delayed inpatient echocardiogram interpretation could lead to delays in providers obtaining important clinical information and could result in patient harm.

The OIG identified the median time elapsed in days for echocardiogram interpretation in November and December of 2021 was approximately eight days.[24] The OIG did not identify adverse events related to the delays.[25]

During interviews with the OIG, the chief of medicine and the virtual inpatient cardiologist acknowledged delays in echocardiogram interpretations. The virtual inpatient cardiologist informed the OIG of being unable to interpret echocardiograms with the available computer software. The facility had implemented changes to address the delays by prioritizing inpatient

[23] Facility SOP 11-10; Facility MCP 11-40.

[24] The median time elapsed in days for echocardiogram interpretations in November 2021 was 7.8 days with half of the interpretation times over this median. The middle half of the interpretation times in November 2021 were from 2.2 to 19.1 days. Similarly, half of the interpretation times in December 2021 were over 8.3 days (median) and the middle half of the interpretation times were from 2.6 to 20.5 days.

[25] The OIG reviewed 20 EHRs of the 86 patients, including 10 patients with the longest interpretation times, to determine whether there were any adverse events related to the delays in the echocardiogram interpretation. VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. "Adverse events are untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm or potential harm directly associated with care or services delivered by VA providers."

echocardiograms for interpretation, utilizing fee-basis appointed cardiologists to assist with result interpretation, and upgrading echocardiogram software.[26]

Hospitalists' Coverage

The OIG determined that while hospitalists reported concerns about providing medical coverage for inpatient and outpatient services when regular providers were off duty, the coverage responsibilities were not outside the scope of hospitalist duties outlined in policy.[27]

The OIG reviewed an April 2020 facility service agreement between Medicine and Geriatric Services (geriatric service agreement), which verified that hospitalists had responsibility for after-hours coverage for the community living center (CLC), ICU, outpatient clinical critical laboratory results, and medical coverage of inpatient psychiatry patients.[28]

The OIG found that in accordance with facility policy, leaders, including the chief of medicine and a CLC leader, and hospitalists did not have a consistent understanding of hospitalists' responsibility to care for CLC patients. The geriatric service agreement tasked hospitalists with determining treatment or disposition of CLC patients after being contacted by CLC staff.[29]

During interviews, hospitalists and a CLC leader told the OIG that CLC nursing staff contacted hospitalists for CLC patient care concerns when CLC providers were off duty; however, in contrast, the chief of medicine told the OIG that CLC staff called 911 when CLC patients had a change in condition.[30]

During an interview with the OIG, the chief of medicine reported being unaware of the geriatric service agreement, which was approved in April 2020, more than one year prior to the chief of medicine joining the facility. Eight months following the interview, a quality management staff member provided information that a facility CLC on-call agreement had been established in November 2022 for CLC nurse practitioners and physician assistants to provide on-call CLC coverage.[31]

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[26] VHA Handbook 5005/129, *Staffing,* April 6, 2020. Fee-basis providers are "individuals who render services to VA on a fee basis, such as employees paid according to a schedule or fees or consultants or attendings used by letter of appointment."

[27] Facility Geriatric Service agreement, Geriatric Service Agreement for Medicine Service/Hospitalists for Community Living Center (CLC), April 22, 2020; Facility MCP 00-43; and Facility MCM 11-89, Reporting of Critical Tests and Critical Results, October 28, 2019.

[28] Facility Geriatric Service agreement, Facility MCP 00-43, and Facility MCM 11-89. During an interview with the OIG, the chief of medicine reported that the facility's policy was to include laboratory confirmation of COVID-19 infections, as critical results.

[29] Facility Geriatric Service agreement.

[30] A CLC leader told the OIG that CLC patients were relocated in May 2020 from the main hospital building to another location on campus. Hospitalists explained that after the relocation, they assessed CLC patients by telephone because physically leaving the facility while providing inpatient care was not possible.

[31] Facility Community Living Center (CLC) Oncall, November 2, 2022.

Consistent understanding of policy between leaders and staff is needed to ensure that patient care is provided as intended.

Deficiency in Hospitalists' Patient Safety Event Reporting

During the inspection, the OIG identified that hospitalists did not report patient safety concerns through the Joint Patient Safety Reporting system.[32] Hospitalists told the OIG of concerns regarding patient safety and limited specialty services but did not report their concerns through the patient safety event reporting system. When the OIG questioned hospitalists about reporting patient safety events at the facility, one hospitalist was unaware of an event reporting mechanism and another hospitalist reported concerns directly to the chief of medicine. The chief of medicine acknowledged receipt of reported concerns, including delays in care, and evaluated the concerns to understand what occurred. Further, the chief of medicine reported that "[reporting concerns] has hopefully been a learning curve" and that training on Joint Patient Safety Reporting was needed.

VHA policy establishes procedures for reporting, analyzing, and addressing patient safety events, which include quality of care concerns. Facility policy instructs facility staff to report any unsafe conditions, including patient safety events and close calls, through the Joint Patient Safety Reporting system, or to the patient safety manager. Incident reporting helps VHA learn about system vulnerabilities and how to address them.[33]

To determine whether the hospitalists' concerns were reported through the Joint Patient Safety Reporting system, the OIG reviewed patient safety events from March 2019 through February 2022. The OIG found only 1 of 20 concerns reported by the hospitalists was entered into the patient safety event reporting system.[34] Failure to report concerns through the established patient incident reporting system impeded the evaluation of potential system-wide issues.

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[32] VHA Handbook 1050.01, March 4, 2011; VHA Directive 1050.01, March 24, 2023. VHA Directive 1050.01 March 24, 2023, references adverse event reporting as a VHA Patient Safety Program foundational principle as compared to VHA Handbook 1050.01, which requires facility staff to report adverse events; Facility MCM 11-22 *Patient Safety Improvement Program*, June 21, 2019; VHA National Center for Patient Safety, *Guidebook for JPSR Business Rules and Guidance*, November 2021, updated December 2022. Joint Patient Safety Reporting is VHA's patient safety event reporting system. The two guidebooks contain similar language related to VHA's patient safety event reporting system.

[33] Facility MCM 11-22, VHA Handbook 1050.01, March 4, 2011; VHA Directive 1050.01, March 24, 2023. The two policies contain similar language related to VHA's learning of system vulnerabilities through patient safety event reporting.

[34] During the inspection, the facility provided the OIG with patient safety events for the identified patients in response to a document request.

Deficiencies in Privileging and Evaluating Intensivists

The OIG found that facility leaders did not follow VHA privileging policy to ensure that an intensivist was granted ICU privileges prior to being assigned in the ICU. In addition, required professional practice evaluations were not completed for both intensivists.[35]

VHA policy states

> When [privileges are] granted, providers should only perform the specified privileges within the designated setting. . . .Providers who do not have the specified privileges for a specific setting are not to practice in that setting, even if they believe the privileges granted are comparable for that setting.[36]

Providers must request privileges for their specific setting. Service chiefs are responsible for reviewing providers' credentials and requested clinical privileges as well as making recommendations to the Executive Committee of the Medical Staff (Medical Executive Board) for privileging actions.[37] The Medical Executive Board reviews recommendations for requested privileges and as appropriate, recommends approval of a provider's privileges to the facility director. Privileges are granted by the facility director.[38]

During the inspection, the OIG reviewed the intensivists' privileging documents, focused professional practice evaluations (FPPEs), and ongoing professional practice evaluations (OPPEs), and interviewed the facility intensivists. During an interview with the OIG, one intensivist reported working as a facility urgent care center and emergency department physician

[35] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. This handbook was in effect at the time of the events discussed in this report and was rescinded and replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021, and 1100.21 (1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA Handbook 1100.19 and VHA Directive 1100.21 (1) contain the same or similar language related to focused professional practice evaluations (FPPEs) and ongoing professional practice evaluations (OPPEs.) An FPPE is used to evaluate the specific privileges and competencies of providers and is required for practitioners new to a facility, as well as practitioners already appointed at a facility who are requesting new privileges. An OPPE is used to provide ongoing medical staff leaders' monitoring of providers' performance of privileges.

[36] VHA Handbook 1100.19, October 15, 2012; VHA Directive 1100.21 (1), March 2, 2023, April 26, 2023. Per VHA Directive 1100.21 (1), setting specific privileges are not required.

[37] VHA Handbook 1100.19, October 15, 2012; VHA Directive 1100.21 (1), March 2, 2023, April 26, 2023. Per VHA Directive 1100.21 (1), setting specific privileges are not required; Facility Charter, *Medical Professional Practice Standards Board* Charter, FY 2019. The facility's Medical Professional Practice Standards Board is a Medical Executive Board subcommittee responsible for reviewing provider privileging requests and making recommendations to the Medical Executive Board on granting clinical privileges for providers.

[38] VHA Handbook 1100.19, October 15, 2012; VHA Directive 1100.21 (1), March 2, 2023, April 26, 2023; The two policies contain the same or similar language related to the review and approval of a providers' privileges.

since May 2015, prior to being assigned to the ICU in September 2021. The intensivist was not granted privileges to provide care in the ICU from November 2021 through April 2022.[39]

The OIG reviewed facility committee meeting minutes and did not find evidence that the Medical Executive Board received or reviewed a request for ICU privileges for the intensivist or recommended approval of the intensivist's privileges to the Facility Director.

During an interview with the OIG in August 2022, the chief of medicine acknowledged not initiating the ICU privileging process when the provider's new ICU assignment had started, and reported that the facility was working to improve tracking provider privileging. The interim Chief of Staff acknowledged there was a gap in supporting the chief of medicine to assist with tracking provider privileging and planned to hire staff to assist the chief of medicine track provider privileging.

The OIG reviewed the EHRs of all 45 patients who received care in the ICU by the intensivist from November 2021 through April 2022, and did not identify any clinical adverse events related to the care provided by the intensivist.[40]

The OIG also found that the chief of medicine failed to ensure the intensivists' professional practice evaluations were completed as required. During an interview with the OIG, the chief of medicine acknowledged not initiating intensivists' professional practice evaluations when they began providing coverage in the ICU because of support staff turnover, and reported that "[failure to initiate professional practice evaluations] was an oversight." The interim Chief of Staff told the OIG there was a gap in supporting the chief of medicine with tracking provider privileging and planned to hire staff to assist the chief of medicine track provider privileging, FPPEs, and OPPEs.[41]

[39] Of note, the intensivist first documented providing care in the ICU in November 2021. A facility quality management staff member reported that, in spring 2022, "it was identified that [the intensivist's] privileges needed to be updated" to include ICU privileges. The intensivist's privileges were updated and approved by an interim Facility Director at that time.

[40] To evaluate the care provided by the intensivist, the OIG reviewed documentation created by the intensivist for each patient from November 2021 (when care was first provided as an intensivist) through April 2022. When applicable, the OIG also reviewed nursing notes, notes from other providers or other ancillary services, pertinent orders, laboratory and test results, and consult requests. A facility quality management staff member provided a report with the intensivist's workload (amount of work performed in a specific time period). The OIG did not independently verify VHA data for accuracy or completeness. The OIG identified that the intensivist provided care to 45 patients in the ICU setting. In May 2023, a facility quality management staff member reported that the chief of medicine reviewed the ICU care provided by the said intensivist from January through July 2022. The facility reported there were no adverse outcomes or clinical concerns identified.

[41] In November 2022, a facility quality management staff member reported that recruitment was in process for two additional positions to assist with tracking provider privileging.

VHA requires service chiefs monitor the professional competency and performance of providers through professional practice evaluations.[42] FPPEs are required any time a provider requests new privileges, and OPPEs are required to be completed at least every six months.

Without following required privileging processes, facility leaders were not assured that the intensivist had the education, training, and competency to provide patient care in the ICU. Additionally, the chief of medicine's failure to complete intensivists' performance evaluations did not allow for evaluation of the intensivists' provision of safe, high-quality care.[43]

The OIG evaluated five peer reviews of four hospitalists to assess concerns that the facility's peer reviews were not conducted by peers and were punitive. The OIG found that all peer reviews were completed by peers and did not find evidence that punitive actions were taken as a result of peer reviews.

The OIG made one recommendation to the Veterans Integrated Service Network Director to ensure that facility leaders follow privileging processes, and five recommendations to the Facility Director to ensure time frames for echocardiogram interpretation are formalized, confirm the ICU SOP and policy for an admission requiring CRRT aligns with care available at the facility, ensure facility staff are educated on CLC delineation of after-hour coverage and hospitalists are educated on reporting patient safety issues, and require the chief of medicine use FPPEs and OPPEs to evaluate provider performance.

Comments

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

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[42] VHA Handbook 1100.19, October 15, 2012; VHA Directive 1100.21 (1), March 2, 2023, amended April 26, 2023; The two policies contain the same or similar language related to the monitoring of professional competency and performance of providers.

[43] VHA Handbook 1100.19, October 15, 2012; VHA Directive 1100.21 (1), March 2, 2023, amended April 26, 2023. The two policies contain the same or similar language related to completion of provider performance evaluations allowing for provision of safe, high-quality care.

Contents

Executive Summary i

Abbreviations xii

Introduction 1

Scope and Methodology 3

Inspection Results 5

- Admission of Patients with Limited Inpatient Specialty Services 5
- Hospitalists' Coverage 15
- Quality Processes 18
- Deficiencies in Privileging and Evaluating Intensivists 20

Conclusion 23

Recommendations 1–6 25

Appendix A: Patient Case Summary 1 26

Appendix B: Patient Case Summary 2 27

Appendix C: VISN Director Memorandum 29

Appendix D: Facility Director Memorandum 31

Glossary 35

OIG Contact and Staff Acknowledgments 40

Report Distribution 41

Abbreviations

CLC	community living center
CT	computerized tomography
CRRT	continuous renal replacement therapy
EHR	electronic health record
EKG	electrocardiogram
FPPE	focused professional practice evaluation
ICU	intensive care unit
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
SOP	standard operating procedure
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to an allegation that the chief of medicine "forced" a hospitalist to admit a patient who needed services that were unavailable at the Fayetteville VA Coastal Health Care System (facility) in North Carolina.[1] The OIG also reviewed reported concerns regarding limited inpatient specialty services, hospitalists' coverage, and peer review processes.[2]

Background

The facility is part of Veterans Integrated Service Network (VISN) 6 and has seven community-based outpatient clinics, two health care centers, and an emergency department located on the facility's main campus in Fayetteville.[3] The facility provides general medicine, surgery, and mental health services. From October 1, 2021, through September 30, 2022, the facility served 88,371 patients and had a total of 128 operating beds: 69 community living center (CLC) and 59 inpatient beds, and according to facility staff, 10 are intensive care unit (ICU) beds.[4] As of May 18, 2022, the facility reported having 72 total operating beds, including 49 inpatient beds and 23 CLC beds. The Veterans Health Administration (VHA) classifies the facility as a level 1c complexity.[5] The facility has a sharing agreement, which describes the VA and Department of

[1] Hospitalists are physicians and advanced practice providers (physician assistants and nurse practitioners) who "typically undergo residency training in general internal medicine. . . or family practice." Hospitalists provide hospital-based care; Society of Hospital Medicine, "What is hospital medicine, and what is a hospitalist?" accessed March 23, 2022, https://www.hospitalmedicine.org/about/what-is-a-hospitalist/.

[2] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. Peer review is a confidential process used to review the clinical care provided by individual healthcare providers.

[3] VHA Directive 1229 (1), *Planning and Operating Outpatient Sites of Care*, July 7, 2017, amended October 4, 2019. A community-based outpatient clinic provides primary and mental health services and may include specialty or subspecialty services. A healthcare center provides "primary care, mental health care, on site specialty services, and performs ambulatory surgery and/or invasive procedures, which may require moderate sedation or general anesthesia." The facility's community-based outpatient clinics are located in, Brunswick County, Goldsboro, Hamlet, Jacksonville, Lee County, Robeson County, and Wilmington. The health care center is located in Fayetteville. Veterans Health Administration, *Facility Trip Pack*, December 2, 2021. The facility transitioned from an urgent care center to an emergency department in March 2021.

[4] VHA Support Service Center (VSSC), *Trip Pack-Operational Statistic Table,* accessed December 2022. The underlined terms are hyperlinks to a glossary or patient case summary. To return from the glossary or patient case summary, press and hold the "alt" and "left arrow" keys together.

[5] VHA Office of Productivity, Efficiency and Staffing. The VHA Facility Complexity Model categorizes each medical facility by complexity level based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex; level 3 facilities are the least complex.

Defense's provision of health care services to patients between the facility and Womack Army Medical Center in Fort Bragg, North Carolina.[6]

Tele-Intensive Care Unit

A memorandum of understanding exists between the VISN 10 Tele-ICU Program, Cincinnati VA Medical Center, and the facility.[7] According to facility policy, ICU expertise is available during evening and weekend hours.[8] A team of remote VA intensivists and nurses collaborate with the facility's ICU staff and hospitalists to provide critical care services. The Tele-ICU team may proactively reach out to, or reactively respond to, facility ICU staff and hospitalists to assist with ICU patient concerns. A facility quality management staff member told the OIG that Tele-ICU began at the facility in December 2020.

Prior OIG Reports

An OIG report was published on May 19, 2020, that addressed the facility's treating capability, delineation of the medical conditions appropriate for admission, and updates to the *Policy for Admission/Discharge/Care of Patients to Intensive Care Unit (ICU)*.[9] Of 12 recommendations made, 1 recommendation relating to community care consults remained open as of June 2023.

Allegations and Related Concerns

In December 2021, the OIG received an anonymous complaint alleging that the chief of medicine "forced" a hospitalist to admit a patient who needed services that were unavailable at the facility and expressing concerns regarding the facility's limited inpatient surgical and cardiology services, hospitalists' coverage, and the peer review process. During the healthcare inspection, the OIG identified concerns with inpatient echocardiogram interpretation timeliness and that the facility's ICU standard operating procedure (SOP) and policy permit admission of

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[6] VA/DoD Sharing Agreement, Master Sharing Agreement and Associated Annexes Among Department of Veterans Affairs Fayetteville VA Coastal Health Care System Medical Center, Womack Army Medical Center, And Fort Bragg Dental Command, facility and Womack Army Medical Center, July 3, 2020–July 2, 2025.

[7] Fayetteville NC VA Coastal Health Care System, *MEMORANDUM OF UNDERSTANDING Between the UNDERSIGNED FACILITIES For TELEHEALTH/TELE-ICU CREDENTIALING AND PRIVILEGING*, September 9, 2020. "The VA TeleCritical Care Program began 10 years ago with two independent programs in Minneapolis and Cincinnati. These separate programs grew locally and regionally and are now merging into the National TeleCritical Care Program which will expand Veteran access to uniform critical care at VA hospitals across the nation," VA, *Six Essential Questions,* https://dvagov.sharepoint.com/sites/VACOTELECC/Shared%20Documents/Six%20Essential%20Questions%20One%20Pager%2002-25-2022%20V3.pdf, accessed March 19, 2022. (This website is not publicly accessible.)

[8] Facility Policy 11-40, Adult Intensive Care Unit (ICU) Admission, Triage and Discharge, January 1, 2022.

[9] Facility Policy 11-40, Policy for Admission/Discharge/Care of Patients to Intensive Care Unit, October 30, 2018; VA OIG, *Delays in Diagnosis and Treatment and Concerns of Medical Management and Transfer of Patients at the Fayetteville VA Medical Center*, North Carolina, Report No. 19-08256-124, May 19, 2020.

patients requiring continuous renal replacement therapy (CRRT) despite the facility not having resources available to support the treatment.[10] The OIG also identified deficiencies in patient safety reporting practices, and privileging and evaluations of intensivists. The allegation and concerns correlated to four categories: limited inpatient specialty services, hospitalists' coverage for CLC and psychiatry, quality processes, and oversight of privileging and evaluating intensivists. Specifically, the healthcare inspection focused on

- a hospitalist's report that the chief of medicine forced a patient admission despite the facility not having a cardiologist available for inpatient consultation;
- limited availability of cardiology inpatient services to support admissions;
- echocardiogram interpretation delays;
- limited availability of surgical inpatient services to support admissions;
- ICU Adult Admission, Triage and Discharge SOP (ICU SOP) and ICU policy that permit admission of patients requiring CRRT to the ICU although the OIG was aware of the facility not having resources to support the treatment;[11]
- hospitalists' concerns about providing medical coverage for other services such as CLC and psychiatry;
- deficiencies in hospitalists' use of the patient safety event reporting system;
- hospitalists' concerns that the facility's peer reviews were not conducted by peers and were punitive; and
- deficiencies in the intensivists' privileging and professional practice evaluations.

Scope and Methodology

The OIG initiated the inspection on January 18, 2022. The period of review was March 26, 2019, through August 2022. The OIG conducted a virtual site visit from February 23 through March 10, 2022.

[10] Echocardiogram interpretation time elapsed in days is the time from the echocardiogram order to the result available. Facility SOP 11-10, *Adult Intensive Care Unit (ICU) Admission, Triage and Discharge Standard Operating Procedure*, January 1, 2022; Facility Policy 11-40, *Adult Intensive Care Unit, (ICU) Admission, Triage and Discharge*, January 1, 2022.; University of Maryland Baltimore Washington Medical Center, "Continuous Renal Replacement Therapy," accessed October 27, 2022, https://www.umms.org/bwmc/health-services/inpatient/patient-education/continuous-renal-replacement-therapy.Continuous renal replacement therapy is a continuous slow motion dialysis treatment that runs 24 hours a day and is used in an ICU to treat patients whose kidneys are not functioning properly.

[11] Facility SOP 11-10; Facility MCP 11-40.

The OIG interviewed the VISN Director and prior acting Chief Medical Officers, the former Facility Director, Chief of Staff, Deputy Chief of Staff, relevant facility leaders and staff from the emergency department, cardiology, medicine, nephrology, nursing, quality management, and surgery services.[12] The OIG also interviewed the former chief hospitalist, hospitalists, and intensivists.[13]

The OIG reviewed VHA directives, handbooks, and memoranda; facility policies, procedures, training and hiring documentation; select providers' privileging documents, focused professional practice evaluations (FPPEs) and ongoing professional practice evaluations (OPPEs); and select peer reviews and Peer Review Committee documentation.[14] The OIG reviewed electronic health records (EHRs) of 25 patients who were identified by the complainant or by facility staff members as being potentially affected by limited inpatient specialty services. Additionally, the OIG reviewed EHRs of 45 patients who received ICU care from an intensivist.[15]

The OIG analyzed interpretation times of 813 completed echocardiogram orders from October 1, 2020, through March 31, 2022. The OIG identified increased interpretation times in November and December of 2021. There were 86 echocardiograms completed in November and December 2021. The OIG reviewed 20 EHRs of the 86 patients, including 10 patients with the longest interpretation times, to determine whether there were any adverse events related to the delay in the echocardiogram interpretation.[16]

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

[12] The former Facility Director left the facility in April 2022. The facility Chief of Staff discussed in the report became the interim Facility Director and the Deputy Chief of Staff became the interim Facility Chief of Staff in April 2022.

[13] One facility provider was a facility emergency department physician and an intensivist during the period of this inspection. As of January 2022, the provider reported having full-time intensivist responsibilities.

[14] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. This handbook was in effect at the time of the events discussed in this report and was rescinded and replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021. The two policies contain the same or similar language related to FPPEs and OPPEs. Medical staff leaders use FPPEs to evaluate competencies of providers to perform newly assigned privileges and is required for new and existing practitioners who request new privileges. Medical staff leaders use OPPEs to provide ongoing monitoring of providers' performance of privileges.

[15] To evaluate the care provided by the intensivist in the ICU, the OIG reviewed documentation by the intensivist for each patient from November 2021 through April 2022. When applicable, the OIG also reviewed nursing notes, notes from other providers or other ancillary services, pertinent orders, laboratory and test results, and consult requests. A facility quality management staff member provided a report with the intensivist's workload (amount of work performed in a specific time period). The OIG did not independently verify VHA data for accuracy or completeness. The OIG identified that the intensivist provided care to 45 patients in the ICU setting.

[16] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. "Adverse events are untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm or potential harm directly associated with care or services delivered by VA providers."

place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews 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 leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

Admission of Patients with Limited Inpatient Specialty Services

The OIG did not identify deficiencies in the chief of medicine's request for a patient admission or the availability of cardiology and surgical services. While not originally the focus of this inspection, the OIG identified delays in inpatient echocardiogram interpretation and an inconsistency in the ICU policy and SOP and the facility's available resources.

Admissions Processes

The OIG did not substantiate that the chief of medicine forced a hospitalist to admit a patient who needed services that were unavailable at the facility. Specifically, the OIG found that the chief of medicine requested a hospitalist admit a patient with a heart condition when a cardiologist was not available for inpatient consultation. However, after consulting with the hospitalist, the chief of medicine recommended the patient be transferred. The OIG did not identify any adverse clinical outcomes associated with this patient's care.[17]

Facility policy indicates that emergency department providers directly contact hospitalists to request an inpatient admission.[18] Further, the policy notes that the requesting provider and hospitalist then "jointly decide as to the appropriateness and type of admission."[19] Lastly, the policy indicates that "the [c]hief [h]ospitalist will be available to resolve disagreements" related

[17] Within the context of this report, the OIG considered an adverse clinical outcome to be death, a progression of disease, or worsening prognosis.

[18] Facility MCP 00-43, *Hospitalist Program,* September 21, 2021.

[19] Facility MCP 00-43.

to admission decisions.[20] Facility policy requires patients who need services that are not available at the facility "be transferred to another facility in an expeditious manner."[21]

Hospitalists are responsible for the initial assessment of patients, to include completion of a history and physical examination, determination of diagnoses, and creation of a treatment plan. As needed, hospitalists consult with specialty and other clinical services and incorporate the resulting information into patients' diagnoses and treatment plans.[22]

During interviews with the OIG, emergency department physicians reported that together with the hospitalists, they decide if a patient is appropriate for admission to the facility. In addition, a hospitalist and an emergency department provider reported that the chief of medicine assisted with inpatient admission decisions and was available to resolve differences in professional opinions. Hospitalists reported considering the availability of specialty services when assessing whether a patient is appropriate for admission and acknowledged challenges when inpatient specialty services is limited.

The OIG noted when differences of professional opinions occurred between emergency department physicians and hospitalists regarding inpatient admissions, the chief of medicine helped resolve discrepancies, consistent with facility policy. [23] Emergency department physicians stated that hospitalists were hesitant to admit patients who might progress in the severity of their illness. The Chief of Staff told the OIG,

> There's lots of the Emergency Medicine [emergency department] folks who do not think that... the hospitalists are necessarily taking care of some of the things they could take [care of]. So, there are opinions [of the emergency department physicians] that the hospitalists are going to transfer more than they should. And there's opinion from the hospitalists. . . or some of the hospitalists, that the [emergency department physicians] are asking us [the facility] to take care of [patients] we shouldn't take care of.

Providers, such as hospitalists and emergency department physicians, as well as facility clinical leaders, including the Chief of Staff and chiefs of medicine and surgery, reported that facility patients are transferred to a hospital with treating capability if clinical services are unavailable. Providers told the OIG that, due to increased cases of COVID-

[20] Facility MCP 00-43. The chief hospitalist supervises hospitalists and other Hospitalist Section staff and oversees the functions of the Hospitalist Section of the Medical Service. A quality management staff member reported to the OIG that in February 2022, the chief hospitalist position was vacant, and the chief of medicine reported being the acting chief hospitalist.

[21] Facility MCP 11-16, *Patient Movement and Management*, February 28, 2020.

[22] Facility MCP 00-43.

[23] Facility MCP 00-43.

19 infections in the community, VA and non-VA hospitals had limited bed availability, which at times made transferring patients from the facility more difficult.[24]

A hospitalist told the OIG of having been forced by the chief of medicine to admit a patient (Patient 1) who required cardiology services that were not available at the facility. (See Appendix A, Patient Case Summary 1.) However, the OIG learned that Patient 1 was not admitted to the facility.

> *Patient 1 had a complex cardiac history that included coronary artery disease, cardiac arrhythmias, high blood pressure; and a pulmonary history that included chronic obstructive pulmonary disease and pulmonary fibrosis. The patient also had prior procedures, including cardiac catheterizations with interventions such as an atherectomy, angioplasty, and cardiac stent placement.*
>
> *In early winter 2021, the patient presented to the emergency department with one week of worsening chest pain with exertion and shortness of breath. The electrocardiogram (EKG) showed a possible myocardial infarction, however, the patient's troponin tests, a blood test to aid in diagnosis of a myocardial infarction, were negative. The emergency department provider recommended admission to rule out acute coronary syndrome for ongoing chest pain. A hospitalist documented, "I don't think it would be safe for the patient to be admitted here [at the facility] unless [cardiology service has] been consulted and agreed." After the emergency department provider told the hospitalist that the on-call facility cardiologist was not available, the hospitalist recommended transferring the patient to a facility with a cardiologist who could evaluate the patient. An intensivist contacted the chief of medicine to determine a decision on the patient's admission. Following the discussion with the intensivist, the chief of medicine requested the hospitalist admit the patient, however, after communicating via electronic messaging with the hospitalist, the chief of medicine recommended contacting a cardiologist at another VA medical center.*
>
> *The patient was subsequently transferred to another VA medical center and received cardiology and pulmonary services.*

The OIG concluded that the hospitalists and emergency department providers followed facility policy, which included making a joint decision regarding the patient's admission. Additionally, the chief of medicine's discussion with the hospitalist after initially

[24] U.S. Department of Health and Human Services/Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, "Impact of Hospital Strain on Excess Deaths During the COVID-19 Pandemic – United States, July 2020–July 2021," November 19, 2021, accessed May 14, 2022. Hospital systems across the nation were stressed with increased cases of COVID-19, which limited availability of inpatient beds, supplies, and staff.

requesting admission and the subsequent decision to transfer Patient 1 was appropriate given the facility's limited inpatient cardiology services.

Limited Inpatient Cardiology Services

The OIG determined the facility had limited inpatient cardiology services available. At the time of the inspection, the facility had the least complex type of ICU (level 4) and was not required to have inpatient cardiology services.[25]

VHA provides guidance for subspecialty availability at facilities with an ICU. Basic services listed for a level 4 ICU include "core hours, or on-call support" for pharmacy services, "limited lab [laboratory] services" and "very limited subset of specialist and sub specialist by referral." Specialists and subspecialists who need to be available by referral are not defined.[26]

During interviews, the OIG was told by a former inpatient cardiologist that the facility had two inpatient cardiologists from July 2019 through September 2021. The former inpatient cardiologist told the OIG of transferring to another VA at the end of September 2021, and the other inpatient cardiologist (virtual inpatient cardiologist) reported working virtually since late summer 2021.

During interviews with the OIG, the Chief of Staff and VISN Director acknowledged having one virtual inpatient cardiologist, and reported limited inpatient cardiology service capability. Facility and VISN leaders told the OIG about ongoing efforts to recruit cardiologists and stated

[25] "Invasive Procedure Complexity," VHA National Surgery Office, accessed June 24, 2022, https://dvagov.sharepoint.com/sites/VHANSO/SitePages/VA-Operative-Complexity-Designation.aspx; "FY20 Complexity Final Model Variables," VHA Office of Productivity, Efficiency and Staffing, accessed June 24, 2022, https://dvagov.sharepoint.com/:x:/r/sites/VHAOPES/_layouts/15/Doc.aspx?sourcedoc=%7B44337330-630E-4A69-A1B2-DD34FC0E3069%7D&file=4.%20FY20%20Complexity%20Final%20Model%20Variables.xlsx&action=default&mobileredirect=true&DefaultItemOpen=1&wdLOR=cB7959324-A81A-423E-8A54-E783D5449B21. (These websites are not publicly accessible.) The ICU level indicates the complexity of the ICU cases that can be handled by the hospital with ICU level 1 being the most complex and ICU level 4 being the least complex.

[26] According to a program manager for the VHA Office of Quality and Patient Safety, criteria for an ICU designation is included in a report issued in 2007 by the VHA Office of Healthcare Analysis and Information Group, which defines services provided in ICUs. Healthcare Analysis and Information Group, Office of the ADUSH for Policy and Planning, *VHA 2007 Survey of Intensive Care Units (ICUs) & Acute Inpatient Medical & Surgical Care in VHA*, November 2007, https://vaww.va.gov/HAIG/ICU/2007ICUAcuteInptMedSurgReport.pdf. This survey includes ICU level criteria and services provided for Basic, Moderate, and Complex designations. (This website is not publicly accessible.)

that if needed cardiology services are not available, a patient would be transferred to another hospital for treatment.[27]

When asked about the facility's use of a virtual inpatient cardiologist, the chief of medicine told the OIG that the virtual inpatient cardiologist does consultations but does not see patients face-to-face. The chief of medicine was aware of hospitalists' concerns with admitting patients without having face-to-face inpatient cardiology consultation available. In response to these concerns, the chief of medicine reported developing an SOP with the virtual inpatient cardiologist to assist hospitalists in determining when a cardiac admission was safe.[28]

While the OIG concluded that the facility did not have face-to-face inpatient cardiology consultation, the OIG found that virtual inpatient cardiology consultation was available. Further, the OIG determined that face-to-face inpatient cardiology consultation was not required, given the facility's level 4 ICU designation.

Delays in Inpatient Echocardiogram Interpretation

The OIG determined that from October 2020 through March 2022, the median time elapsed in days between the time the echocardiogram was ordered to result being available ranged from less than one day to approximately eight days. Delayed inpatient echocardiogram interpretation could lead to delays in providers obtaining important clinical information and could result in patient harm.

Neither VHA nor facility policy define interpretation time for echocardiogram interpretation. In response to an OIG inquiry regarding interpretation times, the chief of medicine provided an informal document indicating "[t]urnaround [time] on reads [of echocardiogram interpretation] for inpatients is 24–48 [hours], unless the [echocardiogram] is performed late Fridays, in which case it will be [interpreted] the next business day."

To evaluate the timeliness of echocardiogram interpretations, the OIG reviewed 813 completed inpatient echocardiogram orders that were entered from October 1, 2020, through March 31, 2022. The OIG analyzed the time elapsed from the time the EHR order was entered to the time the echocardiogram result was available in the EHR. The OIG found that the interpretation times for echocardiograms were consistent each month from October 2020 through October 2021, with median time elapsed in days within one or two days.[29] However, the interpretation time was

[27] The OIG reviewed hiring documentation and found that the facility executive leadership team approved a cardiologist and an advanced practice provider for cardiology at the facility's main campus in February 2021. A March 2022 hiring memorandum indicated that the executive leadership team approved the hiring of three cardiology advanced practice providers.

[28] Facility SOP 111-9, Use of Cardiology Consultation Prior to Acceptance of Cardiac Admissions, December 16, 2021.

[29] Echocardiogram interpretation times from October 2020 through October 2021 ranged from 16.1 to 41.9 hours.

longer for echocardiograms ordered in November and December 2021 and February 2022. In November and December 2021, the median time elapsed in days was approximately eight days (see Figure 1).[30] The OIG reviewed 20 EHRs of the 86 patients, including 10 patients with the longest interpretation times, to determine whether there were any adverse events related to the delay in the echocardiogram interpretation. The OIG did not identify adverse events related to the delays.

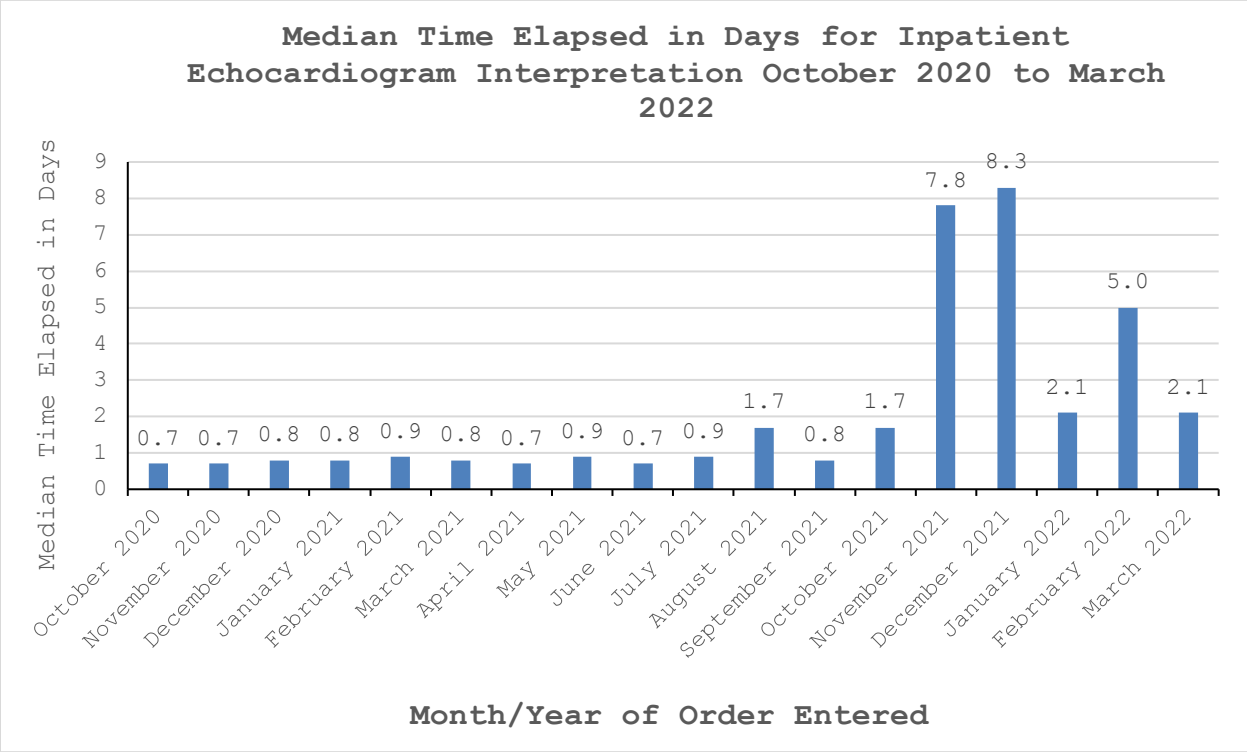

Figure 1. *Median time elapsed in days for inpatient echocardiogram interpretation.*
Source: OIG analysis of 813 completed inpatient echocardiogram EHR orders from October 1, 2020, through March 31, 2022. Echocardiogram orders were analyzed to determine time from the entry of the order to the time when echocardiogram result was available in the EHR.

During interviews, hospitalists informed the OIG that an echocardiogram may take up to a week to be interpreted. The virtual inpatient cardiologist informed the OIG of being unable to interpret echocardiograms with the available computer software. The chief of medicine and virtual inpatient cardiologist further explained that fee-basis appointed cardiologists assisted in interpreting inpatient and outpatient echocardiograms and prioritized inpatient echocardiogram

[30] The median time elapsed in days for echocardiogram interpretations in November 2021 was 7.8 days with half of the interpretation times over this median. The middle half of interpretation times in November 2021 were from 2.2 to 19.1 days. Similarly, half of the interpretation times of echocardiograms in December 2021 were over 8.3 days (median) and the middle half of interpretation times were from 2.6 to 20.5 days.

interpretations.[31] The chief of medicine and virtual inpatient cardiologist acknowledged delays in echocardiogram interpretation but neither identified any adverse patient outcomes related to delays.

The chief of medicine told the OIG that the facility purchased computer echocardiogram software in 2021 and upgraded the software in September 2022. The chief of medicine reported the software upgrade resolved issues with the virtual inpatient cardiologist's inability to read echocardiograms virtually.

The OIG found facility leaders were aware of the delays and had implemented changes to address the delays by prioritizing inpatient echocardiograms for interpretation, appointing fee-basis cardiologists to assist, and upgrading echocardiogram software. The OIG is concerned about the lack of formalized guidance for echocardiogram interpretation times and the potential for patient harm due to interpretation delays.

Limited Inpatient Surgical Services

During the inspection, an emergency department physician, a hospitalist, and the Chief of Staff reported that limited surgical services at the facility impacted decisions on whether to admit or transfer patients who needed surgical services. The OIG determined that, consistent with VHA policy, patients with surgical needs that exceeded the facility's capabilities were transferred to another facility for evaluation and treatment.[32]

VHA designates VA medical facilities that perform invasive procedures as either *inpatient standard*, *inpatient intermediate*, or *inpatient complex* and has established infrastructure requirements for each designation.[33]

> Inpatient standard invasive procedures are typically performed on a same day basis and require an ICU with the ability to provide hemodynamic monitoring and respiratory support of the patient delayed in recovering from general anesthesia; pharmacy and blood bank during weekday duty hours; an ED [emergency

[31] VHA Handbook 5005/129, *Staffing,* April 6, 2020. Fee-basis providers are "individuals who render service to VA on a fee basis, such as employees paid according to a schedule of fees or consultants or attending's used by letter of appointment." The OIG reviewed facility cardiologist fee-basis appointments effective December 2020. The remote cardiologist reported beginning to work remotely in late summer or early fall of 2021 and at that time, the fee-basis cardiologists began interpreting echocardiograms.

[32] VHA Directive 1220 (1), Facility Procedure Complexity Designation Requirements To Perform Invasive Procedures in Any Clinical Setting, amended February 11, 2020.

[33] VHA Directive 1220 (1). VHA requires that diagnostic services, including EKG, laboratory, plain film radiography, and radiology interpretation, are available on-site weekdays and all other times on-call within 60 minutes.

> department] and a physician call schedule to support the invasive services provided.[34]

For standard complexity facilities, VHA requires that anesthesia, general medicine, and general surgery consultations are available on-site during day shift hours on weekdays and, at all other times, on-call within 15 minutes by phone and on-site within 60 minutes.[35]

At the time of the inspection, the facility had an inpatient standard invasive procedure complexity (standard) designation.[36] During interviews with the OIG, facility leaders and surgeons described limitations in the types of surgeries performed at the facility consistent with the inpatient standard complexity designation of the facility.[37] The general surgeons told the OIG that surgical patients exceeding the capacity of the facility are transferred to other facilities for surgical evaluation and procedures, an example of which is the inability to perform bowel surgery.

The OIG reviewed 10 EHRs of patients who needed surgical services.[38] The OIG determined that of the 10 patients, 1 declined surgery, 2 were managed at the facility, and 7 were transferred to non-VA facilities for surgical evaluation. The OIG did not identify any adverse clinical outcomes related to the 10 patients who needed surgical services.[39]

Patient 2 illustrates hospitalists' care coordination for an inpatient who required surgical care beyond the facility's capability and was transferred. (See Appendix B for Patient Case Summary 2.)

> *Patient 2 had a history of chronic back pain, prior lower abdominal surgeries, and more than five years of abnormal liver function tests and was followed by a gastroenterologist. In early fall 2021, the patient presented to the emergency*

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[34] VHA Directive 1220 (1).

[35] VHA Directive 1220 (1).

[36] "Invasive Procedure Complexity," VHA National Surgery Office, accessed June 24, 2022, https://dvagov.sharepoint.com/sites/VHANSO/SitePages/VA-Operative-Complexity-Designation.aspx; "FY20 Complexity Final Model Variables," VHA Office of Productivity, Efficiency and Staffing, accessed June 24, 2022, https://dvagov.sharepoint.com/:x:/r/sites/VHAOPES/_layouts/15/Doc.aspx?sourcedoc=%7B44337330-630E-4A69-A1B2-DD34FC0E3069%7D&file=4.%20FY20%20Complexity%20Final%20Model%20Variables.xlsx&action=default&mobileredirect=true&DefaultItemOpen=1&wdLOR=cB7959324-A81A-423E-8A54-E783D5449B21. (These websites are not publicly accessible.) For standard complexity facilities, VHA requires that anesthesia, general medicine, and general surgery consultation is available on-site during weekdays, day shift, and all other times on-call within 15 minutes by phone and within 60 minutes on-site.

[37] VHA Directive 1220 (1).

[38] During the inspection a total of 25 patients were identified by the complainant or by facility staff members as being potentially affected by limited inpatient specialty services at the facility. Fifteen of the 25 patients did not need surgical services.

[39] No adverse clinical outcomes were identified in the 25 patients reviewed by the OIG.

department with abdominal pain that was a level 10.[40] A night shift emergency department physician ordered laboratory tests, a CT scan [computed tomography] of the abdomen and pelvis, intravenous fluids, antibiotics, and medications as needed for pain and nausea, and requested a hospitalist admit the patient to the facility.'

A radiologist notified the night shift emergency department physician of a critically abnormal CT scan noting a pneumoperitoneum, likely representing a ruptured diverticulitis; fluid in the peritoneum and pelvis; and thickened duodenum.

Upon evaluation for admission, a night shift hospitalist documented concerns that a pneumoperitoneum (free air) found on the patient's CT scan represented a colon perforation requiring surgery and requested that the emergency department physician contact a surgeon to discuss the patient's case. The emergency department physician documented discussing the patient with a surgeon who advised that admission to the hospitalist and intravenous antibiotics were appropriate with reevaluation and transfer to another hospital if the patient failed to respond to treatment in 48 hours. The night shift hospitalist ordered a routine, face-to-face surgical consult for diverticulitis with perforation, with a clinically indicated date of that day.

The patient's abdominal pain, nausea, and vomiting did not improve with intravenous antibiotics. A day shift hospitalist also requested a surgical consult and spoke to a surgeon who reported having "told the [emergency department] physician that, if [the emergency department physician] felt the patient needed surgery, to transfer the patient" as there are no colon surgery privileges at the facility. The day shift hospitalist then requested a community care consult to transfer the patient to another hospital for further surgical evaluation and treatment for services not available at the facility. The patient was transferred that evening to a non-VA hospital for inpatient admission and surgical evaluation. A surgeon canceled both inpatient consults after the patient transferred to a non-VA hospital, noting bowel surgery could not be performed at the facility.

The patient had surgery at the non-VA hospital and a foreign body and pus were found. No diverticulum and no colon inflammation or perforations were identified. The patient was discharged on postoperative day two.

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[40] VHA Pain Management, *Clinical Resources-Defense and Veterans Pain Rating Scale*, accessed April 19, 2023, https://www.va.gov/PAINMANAGEMENT/Resources.asp. Pain intensity is assessed by patients using a 0 to 10 pain rating scale, with 0 indicating the absence of pain and 10 representing the most severe pain.

The OIG determined Patient 2 had a potential need for bowel surgery that exceeded the facility's capability based on complexity designation. The day shift hospitalist recognized that Patient 2's abdominal pain continued and symptoms did not improve with intravenous antibiotics and spoke to the surgeon. The day shift hospitalist then initiated a consult to transfer the patient to a facility with a higher level of surgical services that could perform bowel surgery.

The OIG concluded the facility had limited inpatient surgical services and, consistent with VHA policy, patients with surgical needs that exceeded the facility's capabilities were transferred to another facility for evaluation and treatment.[41]

Intensive Care Unit SOP and Policy Inconsistent with Resources

During the inspection, the OIG identified that the ICU SOP and policy permit admission of patients requiring CRRT, despite the facility not having resources available to support the treatment. [42] The inconsistency could lead to treatment delays in patients requiring CRRT.

The ICU SOP and policy state that "[p]atients requiring services not available at this facility will be referred to an appropriate facility."[43] Additionally, the ICU SOP and policy state, "Adult critically ill patients with the following conditions may be admitted or transferred to the ICUs. . .[p]atients requiring CRRT."[44]

The OIG found that the ICU SOP and policy indicating that a patient may be admitted with a condition requiring CRRT conflicted with the facility's availability of resources, including equipment and trained nursing staff to provide CRRT.[45]

In an interview with the OIG, the chief of medicine acknowledged that "a patient with renal disease requiring renal replacement" would be transferred to an appropriate facility. A facility nephrologist reported the facility does not have the ability to perform CRRT in the ICU.

The OIG concluded the ICU SOP and policy are inconsistent with the facility's available resources to support the admission of patients requiring CRRT. If a patient were to be admitted with a condition requiring CRRT, the patient would require transfer to another facility able to provide CRRT, potentially delaying treatment and risking patient harm.

[41] VHA Directive 1220 (1).

[42] Facility SOP 11-10; Facility MCP 11-40.

[43] Facility SOP 11-10; Facility MCP 11-40.

[44] Facility SOP 11-10; Facility MCP 11-40.

[45] Facility SOP 11-10; Facility MCP 11-40. ICU competencies were provided by the nurse manager for ICU and did not include a competency for CRRT.

Hospitalists' Coverage

The OIG determined that hospitalists provided medical coverage for inpatient, CLC, and outpatient services when regular providers were off duty. Hospitalists' coverage responsibilities were consistent with the scope of hospitalists' duties outlined in policy.[46]

According to an April 2020 facility service agreement between Medicine and Geriatric Services (geriatric service agreement) and facility policies, hospitalist coverage includes [47]

- medical coverage of CLC patients via telephone after 4:30 p.m. on weekdays as well as all day on weekends and holidays,
- ICU admissions between 8 p.m. and 8 a.m.,
- outpatient clinic critical laboratory results after 4:30 p.m. on weekdays,[48] and
- medical coverage of inpatient psychiatry patients.[49]

The OIG determined that at the time of inspection, the facility had nine hospitalists on staff. The chief of medicine reported the facility had 22 acute medicine beds plus 8 beds in the ICU, allowing for a total of no more than 30 acute patients. The chief of medicine further indicated that a minimum of two, and as many as four, hospitalists were on duty at the same time during the day.

Community Living Center

Hospitalists expressed concerns to the OIG about providing coverage for the CLC. While facility policy outlined hospitalists' CLC coverage responsibilities, the OIG found the chief of medicine's understanding of the hospitalists' responsibility to care for CLC patients was not consistent with that of a CLC leader and hospitalists.[50] Consistent understanding of policy between leaders and staff is needed to ensure that patient care is provided as intended.

The geriatric service agreement tasked hospitalists with determining treatment or disposition of CLC patients after being contacted by CLC staff.[51]

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[46] Facility Geriatric Service agreement, Geriatric Service Agreement for Medicine Service/Hospitalists for Community Living Center (CLC), April 22, 2020; Facility MCP 00-43; and Facility MCM 11-89, *Reporting of Critical Tests and Critical Results*, October 28, 2019.

[47] Facility Geriatric Service agreement; Facility MCP 00-43; and Facility MCM 11-89.

[48] Facility MCM 11-89. During an interview with the OIG, the chief of medicine reported that the facility's policy was to include laboratory confirmation of COVID-19 infections as critical results.

[49] Facility MCP 00-43.

[50] Facility Geriatric Service agreement.

[51] Facility Geriatric Service agreement.

In interviews with the OIG, a CLC leader and facility hospitalists explained that CLC nursing staff called hospitalists when CLC providers were off duty and CLC patients needed to be assessed by a provider. The CLC leader told the OIG that CLC patients were relocated in May 2020 from the main hospital building to another location on campus. Hospitalists explained that, since the relocation, they conducted assessments of CLC patients by telephone because physically leaving the facility while providing inpatient care was not possible. Hospitalists reported that sometimes writing orders or recommending a higher level of care for the CLC patient was necessary following a telephone assessment.

In contrast, during an interview with the OIG, the chief of medicine stated that hospitalists did not provide coverage for CLC patients. The chief of medicine reported that CLC staff called 911 when CLC patients had a change in condition. When asked by the OIG about the geriatric service agreement, the chief of medicine reported being unaware of the service agreement. Of note, the agreement was approved in April 2020, more than one year before the chief of medicine joined the facility in August 2021. Eight months following the interview, a quality management staff member provided information that a facility CLC on-call agreement had been established in November 2022 for CLC nurse practitioners and physician assistants to provide on-call CLC coverage.[52]

Hospitalists provided medical coverage of CLC patients until November 2022 when the facility added a process for CLC nurse practitioners or physician assistants to provide CLC medical coverage. The OIG did not identify any concerns with hospitalists or the addition of CLC nurse practitioners or physician assistants providing coverage. However, the OIG found that the chief of medicine's understanding of hospitalist coverage of the CLC conflicted with the geriatric service agreement and practice of hospitalists treating CLC patients.

Intensive Care Unit

The OIG determined that hospitalists admitted and managed patients in the ICU when no intensivist was physically present. The OIG did not identify concerns with the practice, which was consistent with ICU SOP and policy.[53]

As of January 1, 2022, an ICU SOP requires hospitalists to evaluate patients for admission to the ICU and "manage the critical care patients in collaboration with the Tele-ICU physician

[52] Facility Community Living Center (CLC) Oncall, November 2, 2022.

[53] Facility SOP 11-10; Facility MCM 11-40, *Policy for Admission/Discharge/Care of Patients to the Intensive Care Unit*, October 30, 2018. This policy was rescinded and replaced by MCP 11-40*, Policy for Admission/Discharge/Care of Patients to the Intensive Care Unit*, March 23, 2021. Both policies contain the same or similar language regarding hospitalists' responsibilities.

[provider] when the Critical Care physician [intensivist] or designee is not available."[54] Further, policy states that overnight ICU admissions "will be performed by the nocturnal hospitalist." [55]

The ICU nurse manager provided information to the OIG that Tele-ICU physician services became available to hospitalists in December 2020 and were available around-the-clock for consultation. The OIG learned through interviews that two intensivists were hired in fall 2021 and assumed responsibility to care for ICU patients during daytime hours every day.

In interviews, intensivists described handing patient care off to Tele-ICU providers overnight and that hospitalist involvement was limited to admitting patients; assisting at bedside during critical events, such as cardiac arrests; or consulting with a Tele-ICU provider. Leaders, an intensivist, and a hospitalist explained that an intensivist was available through Tele-ICU and the Chief of Staff informed the OIG that hospitalists' responsibilities were limited due to a low ICU census and low acuity patients.

The OIG determined that hospitalists admitted patients to the ICU when intensivists were not on duty and had Tele-ICU as a collaborative resource. The OIG found that this practice continued to allow for the provision of round-the-clock admissions to the ICU and the OIG did not identify concerns with this practice.

Other Coverage

The OIG determined that hospitalists received outpatient clinic critical laboratory results, communicated those results to patients, and provided medical coverage of inpatient psychiatry patients. The OIG found these responsibilities were consistent with facility policy and not beyond the scope of reasonable duties for a hospitalist.[56]

Facility policy states that staff who perform tests notify providers when a patient's test indicates a critical value.[57] Outside of regular business hours, hospitalists are notified of critical values to ensure prompt follow-up.[58] Following notification, hospitalists must immediately communicate the result to the patient and document the "result in the patient's medical record, including the practitioner's assessment, any indicated action, and the follow up plan."[59]

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[54] Facility SOP 11-10.

[55] Facility MCP 00-43.

[56] Facility MCP 00-43 and Facility MCM 11-89.

[57] Facility MCM 11-89, "Test results include the results of laboratory and pathology testing, diagnostic imaging, and diagnostic procedures."

[58] Facility MCM 11-89. Hospitalists receive these results on weekends, holidays, and from 4:30 p.m. to 8:00 a.m. on weekdays.

[59] Facility MCP 11-36, *Standardized Process for Communication of Test Results*, July 25, 2020. Facility MCM 11-89.

During interviews with the OIG, hospitalists described practices consistent with facility policy, which included receiving and addressing critical outpatient laboratory results.[60] The chief of medicine corroborated the hospitalists' practices.

Although not a new responsibility, one hospitalist noted that the increased volume of calls received during the COVID-19 pandemic made addressing laboratory results particularly challenging. The hospitalist told the OIG of communicating positive COVID-19 results to 20 or 30 patients per night, an increase from previously 5 to 10 calls per night. The chief of medicine explained that following an increase in positive COVID-19 results, the facility addressed the increase by hiring more personnel to staff the facility's COVID-19 testing clinic.

According to the facility hospitalist policy, because "hospitalists are responsible for the management of inpatient medical care 24 hours per day, seven days per week," they may be required to assess patients admitted to inpatient psychiatry for medical issues.[61]

In interviews with the OIG, facility hospitalists reported occasionally being asked to evaluate patients in the inpatient psychiatry unit. However, hospitalists explained that assessments were limited to medical conditions and did not include psychiatric evaluations, which would be outside of their expertise. The Chief of Staff and chief of medicine confirmed this practice during interviews.

The OIG concluded that hospitalists provided after-hours coverage of the CLC and admission coverage for the ICU; received outpatient clinic critical laboratory results, communicated those results to patients; and provided medical coverage for psychiatry patients. The OIG found these responsibilities were consistent with facility policy and not beyond the scope of reasonable hospitalist duties.[62]

Quality Processes

The OIG determined a deficiency in hospitalists' use of the patient safety event reporting system. Specifically, hospitalists told the OIG of concerns regarding patient safety and limited specialty services but did not report their concerns through the patient safety event reporting system. In addition, the OIG determined that peer reviews of hospitalists were completed by peers and did not find evidence that punitive actions were taken as a result of peer reviews.

[60] Facility MCM 11-89.

[61] Facility MCP 00-43.

[62] Facility MCP 00-43 and Facility MCM 11-89.

Deficiency in Hospitalists' Patient Safety Event Reporting

VHA policy establishes procedures for reporting, analyzing, and addressing patient safety events, which include quality of care concerns.[63] Facility policy instructs facility staff to report any unsafe conditions, including patient safety events and close calls, through the Joint Patient Safety Reporting system or to a patient safety manager.[64] Once patient safety events are reported, processes are used to mitigate recurring events, including evaluation of contributing factors, associated actions, and outcome measures. Patient safety reporting helps VHA learn about system vulnerabilities and how to address them.[65]

To determine whether the hospitalists' concerns were reported through the Joint Patient Safety Reporting system, the OIG reviewed patient safety events from March 2019 through February 2022. The OIG found only 1 of 20 concerns reported by the hospitalists was entered into the patient safety event reporting system.[66]

During interviews, when the OIG questioned hospitalists whether the Joint Patient Reporting System was used to report patient safety concerns, one hospitalist was unaware of the reporting system and another hospitalist explained that they reported concerns directly to the chief of medicine. The chief of medicine acknowledged receipt of reported concerns, including delays in care, and evaluated the concerns to understand what occurred. Further the chief of medicine reported that "[reporting concerns] has been hopefully a learning curve" and training on Joint Patient Safety Reporting was needed. The patient safety manager reported that, while having received patient safety event reports from physicians at the facility, "they are few and far between."

The OIG determined that, while some hospitalists reported patient safety concerns to the OIG, they did not report these concerns through the established patient safety event reporting system in accordance with VHA policy. Failure to report concerns to the patient safety manager impeded the use of patient safety processes to mitigate recurrence of concerns.

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[63] VHA Handbook 1050.01, March 4, 2011; VHA Directive 1050.01, March 24, 2023. The two policies contain similar language related to procedures for reporting, analyzing, and addressing patient safety events.

[64] Facility MCM 11-22 *Patient Safety Improvement Program*, June 21, 2019; VHA National Center for Patient Safety, *Guidebook for JPSR Business Rules and Guidance*, November 2021; revision VHA National Center for Patient Safety, *JPSR Guidebook*, December 2022. The JPSR is VHA's patient safety event reporting system. The two business rules contain similar language related to VHA's patient safety event reporting system.

[65] VHA Handbook 1050.01. VHA Handbook 1050.01, March 4, 2011; VHA Directive 1050.01, March 24, 2023. The two policies contain similar language related to VHA's learning of system vulnerabilities through patient safety event reporting.

[66] The facility provided the OIG with patient safety events for patients identified by hospitalists to the OIG during the inspection. A facility nurse entered the concern into the Joint Patient Safety Reporting System.

Peer Reviews of Hospitalists

Peer review is a confidential process used to review the clinical care provided by individual healthcare providers. VHA policy requires that a peer reviewer must have "similar or more advanced education, training, experience, licensure, clinical privileges, or scope of practice" as the clinician being reviewed.[67] Peer reviews are "intended to promote confidential and non-punitive assessments of care at the individual [provider] level."[68]

The OIG evaluated five peer reviews of four hospitalists to assess concerns that the facility's peer reviews were not conducted by peers and were punitive. The OIG found that all peer reviews were completed by peers and did not find evidence that punitive actions were taken as a result of peer reviews.[69]

A quality management staff member reported being aware of provider concerns and repeatedly telling providers that peer review is not a punitive process. During an interview with the OIG, the quality management staff member reported informing service chiefs of provider concerns and suggesting the service chiefs discuss the concerns with their staff.

Facility leaders acknowledged staff concerns regarding the peer review process being perceived as punitive. The former Facility Director told the OIG about requesting quality management staff to "look to see if there's evidence to support the [punitive] claim" and found no evidence to support the claim. The OIG reviewed Peer Review Committee documentation for peer reviews that required follow-up and found the actions were educational and not punitive.

The OIG concluded that peers performed hospitalists' peer reviews and did not find evidence that the peer review process was punitive.

Deficiencies in Privileging and Evaluating Intensivists

During the inspection, the OIG identified deficiencies in privileging and evaluating intensivists. Specifically, as required by VHA policy, the chief of medicine failed to ensure an intensivist was granted ICU privileges, and complete required professional practice evaluations for the intensivists.[70]

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[67] VHA Directive 1190.

[68] VHA Directive 1190.

[69] VHA Directive 1190.

[70] VHA Handbook 1100.19 *Credentialing and Privileging*, October 15, 2012. This handbook was in effect at the time of the events discussed in this report until it was rescinded and replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021, and 1100.21 (1), *Privileging*, March 2, 2023, amended April 26, 2023. The three policies contain the same or similar language related to the process for granting providers' privileges.

Intensivist's ICU Privileges

Privileging refers to the process of approving a provider to perform certain procedures and services in a specific facility.[71]

VHA's 2012 policy, in effect at the time of the inspection, stated,

> When [privileges are] granted, providers should only perform the specified privileges within the designated setting.... Practitioners who do not have the specified privileges for a specific setting are not to practice in that setting, even if they believe the privileges granted are comparable for that setting.[72]

Service chiefs are responsible for reviewing providers' credentials and requested clinical privileges and then making recommendations to the Executive Committee of the Medical Staff (Medical Executive Board) for privileging actions.[73] The Medical Executive Board reviews recommendations for requested privileges and following the review, as appropriate, recommends approval of a provider's privileges to the facility director. Privileges are granted by the facility director.[74] When a provider requests privileges in more than one service, the applicable service chiefs must recommend the privileges specific to that service.[75]

After review of the two intensivists' privileges and information obtained from facility quality management staff, the OIG found that prior to being assigned to the ICU in September 2021, one of the two intensivists was an urgent care center and emergency department physician since May 2015.[76] The OIG found that the intensivist was not granted privileges to provide care in the ICU from November 2021 through April 2022.[77]

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[71] VHA Handbook 1100.19, October 15, 2012; VHA Directive 1100.21 (1), March 2, 2023, amended April 26, 2023. The two policies contain the same or similar language related to the definition of privileging.

[72] VHA Handbook 1100.19, October 15, 2012; VHA Directive 1100.21 (1), March 2, 2023, amended April 26, 2023. Per VHA Directive 1100.21 (1), setting specific privileges are not required. Privileges must be delineated for each clinical service at the facility.

[73] Facility Charter, *Medical Professional Practice Standards Board Charter*, FY 2019. The facility's Medical Professional Practice Standards Board is a Medical Executive Board subcommittee responsible for reviewing provider privileging requests and making recommendations to the Medical Executive Board on granting clinical privileges for providers.

[74] VHA Handbook 1100.19, October 15, 2012; VHA Directive 1100.21 (1), March 2, 2023, amended April 26, 2023. The two policies contain the same or similar language related to review and approval of providers' privileges.

[75] VHA Handbook 1100.19, October 15, 2012; VHA Directive 1100.21 (1), March 2, 2023, amended April 26, 2023. The two policies contain the same or similar language related to the process for service chiefs' responsibilities when a provider requests privileges for multiple services.

[76] During an interview with the OIG, the said intensivist reported being assigned to the ICU in September 2021.

[77] Of note, the intensivist first documented providing care in the ICU in November 2021.

A facility quality management staff member reported that in spring 2022, "it was identified that [the intensivist's] privileges needed to be updated" to include ICU privileges. The intensivist's privileges were updated and approved by the interim Facility Director at that time.[78]

The OIG did not find evidence in committee meeting minutes that the Medical Executive Board reviewed a request for ICU privileges for the intensivist or recommended approval of the intensivist's privileges to the Facility Director.

The OIG reviewed the EHRs of all 45 patients who received care in the ICU from the intensivist from November 2021 through April 2022 and did not identify any clinical adverse events related to the care provided by the intensivist.[79] The second intensivist's privileges were appropriately designated for the ICU setting.

During an interview with the OIG, the chief of medicine acknowledged not initiating the ICU privileging process when the provider's new ICU assignment had started and reported that the facility is working to improve tracking of provider privileging. The interim Chief of Staff acknowledged there was a gap in supporting the chief of medicine to assist with tracking provider privileging and planned to hire staff to assist the chief of medicine track provider privileging. [80]

The OIG concluded that although an intensivist had privileges for the emergency department setting, when the intensivist began working in the ICU, facility leaders did not follow privileging processes per VHA policy to ensure that the intensivist was granted ICU privileges prior to being assigned to the ICU. Additionally, facility committees did not review the intensivist's requested ICU privileges prior to the interim Facility Director's approval of the privileges. Without following required privileging processes, facility leaders were not assured that the intensivist had the education, training, and competency to provide patient care in the ICU.

[78] A quality management staff member reported that during an audit the facility found that the chief of medicine did not sign the updated intensivist's privileging request. The OIG confirmed that the chief of medicine signed the intensivist's privileging request in July 2022.

[79] To evaluate the care provided by the intensivist, the OIG reviewed documentation by the intensivist for each patient from November 2021 (when care was first provided as an intensivist) through April 2022. When applicable, the OIG also reviewed, nursing notes, notes from other providers or other ancillary services, pertinent orders, laboratory and test results, and consult requests. In May 2023, a facility quality management staff member reported that the chief of medicine reviewed the ICU care provided by the said intensivist from January through July 2022. The facility reported there were no adverse outcomes or clinical concerns identified.

[80] In November 2022, a facility quality management staff member reported that recruitment was in process for two additional positions to assist with tracking provider privileging.

Deficiencies in Intensivists' Professional Practice Evaluations

VHA requires service chiefs monitor the professional competency and performance of providers through professional practice evaluations.[81] FPPEs are required any time a provider requests new privileges. OPPEs are required to be completed at least every six months. Data used to determine a provider's competency must be "practitioner specific, reliable, easily retrievable, timely, justifiable, comparable, and risk adjusted." According to VHA, monitoring of privileged providers is essential to evaluate the care provided and identify practice trends, which impact the quality of care and patient safety.[82]

The OIG reviewed FPPEs and OPPEs for both ICU intensivists and determined the chief of medicine did not complete the evaluations of either intensivist as required. Specifically, the OIG found that one intensivist's FPPE and OPPE from November 2021 through August 2022 and an FPPE for the second intensivist, who was granted ICU privileges in April 2022, were not completed.

During an interview with the OIG, the chief of medicine acknowledged not initiating intensivists' professional practice evaluations when they began providing coverage in the ICU because of support staff turnover and also that "it was an oversight." The interim Chief of Staff reported a plan to provide staffing support to assist the chief of medicine with FPPE and OPPE tracking.

The OIG found that the chief of medicine did not ensure that the intensivists' competency and performance of ICU privileges was evaluated. This deficiency did not allow for evaluation of the intensivists' provision of safe, high-quality care.[83]

Conclusion

The OIG did not substantiate the allegation that the chief of medicine forced a hospitalist to admit a patient who needed services that were unavailable in the facility. Further, the OIG did

[81] VHA Handbook 1100.19, October 15, 2012. This handbook was in effect at the time of the events discussed in this report and was rescinded and replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021, and 1100.21 (1), Privileging, March 2, 2023, amended April 26, 2023. VHA Handbook 1100.19 and VHA Directive 1100.21 (1) contain the same or similar language. The two policies contain the same or similar language related to monitoring professional competency and performance of providers.

[82] VHA Handbook 1100.19, October 15, 2012; VHA Directive 1100.21 (1), March 2, 2023, amended April 26, 2023. The two policies contain the same or similar language related to completion of provider performance evaluations allowing for provision of safe, high-quality care.

[83] VHA Handbook 1100.19 *Credentialing and Privileging*, October 15, 2012. This handbook was in effect at the time of the events discussed in this report until it was rescinded and replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021, and VHA Directive 1100.21 (1) *Credentialing*, March 2, 2023, amended April 26, 2023. The three policies contain the same or similar language related to FPPEs and OPPEs.

not validate concerns regarding the availability of inpatient cardiology and surgical services, the scope of hospitalist coverage, or the peer review process. While limited, the available inpatient cardiology and surgical services were consistent with the facility's complexity designation.

The OIG determined that hospitalists provided coverage for inpatient settings as well as the CLC and outpatient services; however, these duties were not out of scope for hospitalists. Peer review processes adhered to required quality processes and were not punitive in nature.

During the inspection, the OIG determined that inpatient echocardiograms were not interpreted timely, although the OIG was unable to identify a VHA or facility policy for echocardiogram interpretation time. The median time elapsed in days for interpretation for echocardiograms ordered in November and December 2021, and in March 2022, was approximately eight days. Facility leaders and the virtual inpatient cardiologist attributed the delay to deficiencies in staffing and software functionality, issues that were addressed by appointing fee-basis cardiologists and upgrading echocardiogram software.

While reviewing relevant policies, the OIG found that, although the ICU SOP and policy permit the admission of patients who require CRRT, the facility lacks the equipment and trained nursing staff to provide CRRT. The OIG is concerned that if a patient was to be admitted with a condition requiring CRRT, the patient would require transfer to a facility capable of providing CRRT, potentially delaying treatment and risking patient harm.

Although the OIG did not validate concerns regarding hospitalists covering the CLC, the OIG found leaders, including the chief of medicine and a CLC leader, and hospitalists, did not have a consistent understanding of hospitalists' responsibility to care for CLC patients. Consistent understanding of policy between leaders and staff is needed to ensure that patient care is provided as intended. The chief of medicine reported that in November 2022, CLC nurse practitioners and physician assistants began providing on-call coverage and that a facility CLC on-call agreement had been established.

While some hospitalists reported patient safety concerns to the OIG, they did not report these concerns through the Joint Patient Safety Reporting system in accordance with facility policy. Failure to report patient safety concerns as required inhibits the patient safety manager's ability to intervene upon safety concerns.

The OIG determined that the facility leaders failed to ensure privileging and evaluating intensivists occurred as required by policy. Specifically, although an intensivist had privileges to provide treatment and perform procedures in the emergency department, when the intensivist began working in the ICU, the intensivist was not privileged to provide care in the ICU setting. Additionally, the chief of medicine did not ensure that intensivists' performance was monitored through FPPEs and OPPEs. Due to these deficiencies, the quality of care intensivists rendered ICU patients was not adequately evaluated.

Recommendations 1–6

1. The Fayetteville VA Coastal Health Care System Director ensures time frames for interpretation of echocardiograms are formalized and monitors for compliance.

2. The Fayetteville VA Coastal Health Care System Director reviews Facility Policy 11-40, *Adult Intensive Care Unit (ICU) Admission, Triage and Discharge* dated January 2022 and SOP 11-10, *Adult Intensive Care Unit (ICU) Admission, Triage and Discharge Standard Operating Procedure* and confirms that policy and procedures for an admission requiring continuous renal replacement therapy align with equipment and trained staff available at the facility.

3. The Fayetteville VA Coastal Health Care System Director ensures facility staff are educated on the community living center delineation of after-hour coverage and monitors compliance.

4. The Fayetteville VA Coastal Health Care System Director confirms hospitalists are educated on reporting patient safety issues and monitors patient safety reporting compliance.

5. The VA Mid-Atlantic Health Care Network Director reviews privileging processes and policies to ensure that facility leaders follow privileging processes and monitors compliance.

6. The Fayetteville VA Coastal Health Care System Director requires the chief of medicine to use focused professional practice evaluations and ongoing professional practice evaluations to evaluate provider performance per policy and monitors compliance.

Appendix A: Patient Case Summary 1

The patient was in their seventies with a past medical history for complex coronary artery disease requiring cardiac catheterizations and cardiac interventions.[84] The patient had a history of premature ventricular contractions, high blood pressure, hyperlipidemia, chronic obstructive pulmonary disease, and pulmonary fibrosis. In late summer 2021, the patient had cardiac catheterizations with interventions including an atherectomy, angioplasty, and a cardiac stent placement.

In early winter 2021, the patient presented to the emergency department complaining of one week of worsening chest pain with exertion and shortness of breath. The EKG showed a possible myocardial infarction and premature ventricular contractions. A troponin test, a blood test used to help diagnose a heart attack, was negative twice. The day shift emergency department physician noted the patient needed admission to rule out an acute coronary syndrome for ongoing chest pain. The emergency department physician contacted a day shift hospitalist to admit the patient. The hospitalist documented accepting the patient for admission only if there was a cardiologist on-call. The emergency department physician documented there was no cardiologist on-call.

The day shift hospitalist's note indicated the chief of medicine requested the patient be admitted. The hospitalist recommended transferring the patient to a facility with a cardiologist available to evaluate the patient as the patient had a similar presentation, similar EKG, and normal troponins in late summer 2021. At that time, a cardiologist had recommended transferring the patient to another VA hospital for treatment.

A night shift emergency department physician documented calling the intensivist about the patient and noted the intensivist communicated with the chief of medicine about the patient. The day shift hospitalist documented having been contacted by the chief of medicine and explaining to the chief of medicine the patient's cardiac history and concern for patient safety if the patient was admitted without cardiology consultation. Per the hospitalist's note, the chief of medicine then recommended the hospitalist contact the on-call cardiologist at another VA medical center. The hospitalist discussed the patient with the on-call cardiology resident at the other VA medical center.

A night shift hospitalist documented a discussion with a night shift emergency department physician and a cardiologist at the other VA medical center. The patient was accepted for transfer to the other VA emergency department due to ongoing angina. The patient was admitted and received cardiology and pulmonary (lung) consultations and care at the other VA medical center.

[84] The OIG uses the singular form of they (their) in this instance for privacy purposes.

Appendix B: Patient Case Summary 2

The patient, in their fifties, had chronic back pain, a history of abnormal liver function tests for more than five years, was followed by a gastroenterologist, and had prior lower abdominal surgeries.

In early fall 2021, the patient presented to the facility's emergency department with nursing triage assessment noting the patient complained of abdominal pain since earlier that day. The patient rated their pain at a 10 and denied nausea and vomiting.[85] Nursing staff reassessed the patient, noting the patient was pale and had increasing abdominal discomfort all over the abdomen but especially the left lower quadrant. The night shift emergency department physician evaluated the patient and found abdominal tenderness, which was worse in the left lower quadrant, with guarding and rebound tenderness. The emergency department physician ordered laboratory tests, a CT scan of the abdomen and pelvis, intravenous fluids, antibiotics, and medications as needed for pain and nausea.

A radiologist notified the night shift emergency department physician of a critically abnormal CT scan noting a pneumoperitoneum, likely to represent ruptured diverticulitis; fluid in the peritoneum and pelvis; and thickened duodenum. Continued follow-up was suggested "as small evolving abscess cannot be completely excluded in the pelvis and left peritoneum."

The night shift emergency department physician called the night shift hospitalist to admit the patient. The hospitalist documented, "I will feel uncomfortable admitting a bowel perforation without surgical support." The hospitalist requested the emergency department physician discuss the patient with the surgeon on-call as the hospitalist felt the pneumoperitoneum on the CT scan was a colon perforation. The emergency department physician documented discussing the patient with a surgeon, and noted the surgeon determined that medical admission and intravenous antibiotics were appropriate with reevaluation and transfer to another hospital if the patient failed to respond in 48 hours.

The night shift hospitalist admitted the patient to the hospital early the following day, noting the patient had nausea, vomiting, and abdominal pain. On examination, the night shift hospitalist noted the abdomen was mildly distended and tender, mostly in the left lower quadrant. Antibiotics and medication for nausea and pain were continued. The night shift hospitalist ordered a routine face-to-face surgical consult for diverticulitis with perforation of the colon and abscess. Later that morning, the day shift hospitalist noted the patient's pain as a 10. On evaluation, the day shift hospitalist noted the abdomen was distended, without bowel sounds, with diffuse tenderness. The day shift hospitalist spoke to the surgeon on-call, noting the surgeon

[85] VHA Pain Management, Clinical Resources, *Defense and Veterans Pain Rating Scale Complete Assessment,* Internal Reference Only. Pain intensity is assessed by patients using a 0 to 10 pain rating scale, with 0 indicating the absence of pain and 10 representing the most severe pain.

stated telling the emergency department physician to transfer the patient if the emergency physician felt that the patient needed surgery. A surgical consult was also requested by this hospitalist.

The day shift hospitalist requested a community care consult to transfer the patient to another hospital for further evaluation and treatment for surgical services not available at the facility. The patient was transferred that evening to a non-VA hospital for inpatient admission and surgical evaluation. The facility surgeon canceled both surgical consult requests the day after the patient was discharged from the facility. The surgeon's rationale for canceling the consults was the lack of colon surgery privileges.

The patient had surgery the following day at the non-VA hospital. The operative note described finding a foreign body encased in the omentum with pus. No diverticulum, colon inflammation, or perforations were identified. The patient was discharged on postoperative day two.

Appendix C: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 10, 2023

From: Director, VA Mid-Atlantic Health Care Network (10N06)

Subj: Healthcare Inspection—Deficiencies in Echocardiogram Interpretation Timeliness, Facility Policies, Patient Safety Reporting, and Oversight at the Fayetteville VA Coastal Health Care System in North Carolina

To: Director, Office of Healthcare Inspections (54HL09)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. I appreciate the opportunity to review the draft report: Deficiencies in Echocardiogram Interpretation Timeliness, Facility Policies, Patient Safety Reporting, and Oversight at the Fayetteville VA Coastal Health Care System in North Carolina.

2. I would like to thank the OIG Inspection team for a thorough review which identified opportunities for improvement.

3. I have reviewed the OIG recommendations, facility response and action plans and am committed to supporting process improvement and sustainment at the Fayetteville VA Coastal Health Care System and throughout VISN 6.

(*Original signed by:*)

Jonathan S. Benoit
Deputy Network Director
for
Paul S. Crews, MPH, FACHE
Network Director

VISN Director Response

Recommendation 5

The VA Mid-Atlantic Health Care Network Director reviews privileging processes and policies to ensure that facility leaders follow privileging processes and monitors compliance.

_X_ Concur

____Nonconcur

Target date for completion: August 31, 2023

Director Comments

Privileging processes and policies are a component of annual site reviews conducted by the Chief Medical Officer (CMO). The Fayetteville Coastal Health Care System site visit is scheduled for July 11 – 12, 2023. During that time, VISN 6 CMO Team will assess privileging processes and compliance in an audit which includes files incorporated into the site's self-assessment from the 2nd quarter, Fiscal Year 2023, as well as additional files to ensure compliance with privileging processes as set forth by the VA National Credentialing and Privileging Office directive and standard operating procedures. Any non-compliance with privileging processes and policies discovered during CMO site visit will result in an action plan that will be reported and tracked to completion by the VISN 6 Credentialing and Privileging Manager and the Deputy Chief Medical Officer.

Appendix D: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 30, 2023

From: Fayetteville, North Carolina VA Coastal Healthcare System (565/00)

Subj: Healthcare Inspection—Deficiencies in Echocardiogram Interpretation Timeliness, Facility Policies, Patient Safety Reporting, and Oversight at the Fayetteville VA Coastal Health Care System in North Carolina

To: Director, VA Mid-Atlantic Health Care Network (10N06)

1. The Executive Director of the Fayetteville VA Coastal Health Care System has reviewed the draft report and concurs with the findings.
2. A plan for corrective actions to include timeline for completion and sustainment of improvements has been completed.

(*Original signed by*:)

Marri "Nicki" Fryar, MBA, MHA, BSN, NE-BC, VHA-CM
Executive Director
Fayetteville NC VA Coastal Health Care System

Facility Director Response

Recommendation 1

The Fayetteville VA Coastal Health Care System Director ensures time frames for interpretation of echocardiograms are formalized and monitors for compliance.

_X_ Concur

____Nonconcur

Target date for completion: September 1, 2023

Director Comments

The Fayetteville VA Medical Center will continue to target echocardiography processes that are consistent with our peer community level VA hospitals. There are no published standards or national polices on interpreting timelines. The Chief of Medicine will continue to ensure targeting 48-hour interpretation intervals on inpatient echocardiograms. Compliance data will be monitored with a 90% goal for 6 consecutive months and the data will be reported to Medical Executive Council.

Recommendation 2

The Fayetteville VA Coastal Health Care System Director reviews Facility Policy 11-40, Adult Intensive Care Unit (ICU) Admission, Triage and Discharge, dated January 2022 and SOP 11-10, *Adult Intensive Care Unit (ICU) Admission, Triage and Discharge Standard Operating Procedure* and confirms that policy and procedures for an admission requiring continuous renal replacement therapy align with equipment and trained staff available at the facility.

_X_ Concur

____Nonconcur

Target date for completion: September 1, 2023

Director Comments

The Chief of Medicine will ensure that Facility Policy 11-40, *Adult Intensive Care (ICU) Admission, Triage, and Discharge* dated January 2022 and SOP 11-10, *Adult Intensive Care Unit (ICU) Admission, Triage and Discharge Standard Operating Procedure* confirms that policy and procedures for an admission requiring continuous renal replacement therapy align with equipment and trained staff available at the facility. Compliance data will be monitored with a 90% goal for 6 consecutive months and the data will be reported to Medical Executive Council.

Recommendation 3

The Fayetteville VA Coastal Health Care System Director ensures facility staff are educated on the community living center delineation of after-hour coverage and monitors compliance.

_X_ Concur

____Nonconcur

Target date for completion: September 1, 2023

Director Comments

The Chief of Geriatrics/LTC will educate hospitalist and community living staff on the community living center delineation of after-hour coverage. This information will be added to the orientation checklist for new CLC and hospitalist staff. Compliance with education will be monitored with a 90% goal with staff educated and the data will be reported to Medical Executive Council.

Recommendation 4

The Fayetteville VA Coastal Health Care System Director confirms hospitalists are educated on reporting patient safety issues and monitors patient safety reporting compliance.

_X_ Concur

____Nonconcur

Target date for completion: September 1, 2023

Director Comments

Patient safety event reporting training is in progress with all hospitalists in different delivery methods. All current hospitalists staff are being re-educated on how to report patient safety issues in the Joint Patient Safety Reporting (JPSR) system in accordance with VHA Directive 1050.01. Compliance with training will be reported to the Medical Executive Council. Goal: 90% compliance. Patient safety event reporting training is within the new employee orientation and new provider orientation programs which will complete training for new onboarded hospitalist.

Patient safety event reporting can be anonymous, so monitoring hospitalist specific reporting compliance is not achievable in JPSR. During the education session, the Patient Safety Manager is promoting and encourage hospitalist to enter patient safety adverse events and close calls into JPSR per VHA Directive 1050.01 guidance.

Recommendation 6

The Fayetteville VA Coastal Health Care System Director requires the chief of medicine use focused professional practice evaluations and ongoing professional practice evaluations to evaluate provider performance per policy and monitors compliance.

_X_ Concur

____Nonconcur

Target date for completion: September 1, 2023

Director Comments

Chief of Medicine will conduct focused professional practice evaluations (FPPE) and ongoing professional practice evaluations (OPPE) to evaluate provider performance per VHA Directive 1100.21 *Privileging*, dated April 26, 2023. FPPE will be for initial appointments and completed on the first day of clinical care and/or completed for request of initial privileges and if the provider has been out of clinical practice greater than 30 days. OPPE will be completed for a period not to exceed an eight-month timeframe within three-year reappointment cycle. Compliance data will be monitored with a 90% goal for 6 consecutive months and the data will be reported to Medical Executive Council.

Glossary

To go back, press "alt" and "left arrow" keys.

abscess. "A localized collection of pus surrounded by inflamed tissue."[1]

acuity. Acuity (patient classification system) is used to predict patient requirements for management of patient care (personnel resources, costs, and quality.)[2]

acute coronary syndrome. Acute coronary syndrome is "an umbrella term for situations where the blood supplied to the heart muscle is suddenly blocked."[3]

angina. Angina "is a type of chest pain caused by reduced blood flow to the heart."[4]

angioplasty. An angioplasty is a procedure to unclog blocked arteries.[5]

atherectomy. Removal of plaque "from within a blood vessel by utilizing a catheter usually fitted with a cutting blade or grinding burr."[6]

blood bank. "A place for storage of or an institution storing blood or plasma."[7]

bowel sounds. "Bowel sounds (abdominal sounds) are made by the movement of the intestines" as food is pushed through.[8]

cardiac catheterizations. "Cardiac catheterization is a procedure in which a thin, flexible tube (catheter) is guided through a blood vessel to the heart to diagnose or treat certain heart conditions, such as clogged arteries or irregular heartbeats."[9]

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[1] *Merriam-Webster.com Dictionary*, "abscess," accessed April 23, 2022, https://www.merriam-webster.com/dictionary/abscess.

[2] Bonnie M. Jennings, *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*. (National Library of Medicine, April 2008). Chapter 23: "Patient Acuity."

[3] American Heart Association, "acute coronary syndrome," accessed April 27, 2022, https://www.heart.org/en/health-topics/heart-attack/about-heart-attacks/acute-coronary-syndrome.

[4] Mayo Clinic, "angina," accessed May 14, 2022, https://www.mayoclinic.org/diseases-conditions/angina/symptoms-causes/syc-20369373.

[5] Mayo Clinic, "coronary angioplasty and stents," accessed April 22, 2022, https://www.mayoclinic.org/tests-procedures/coronary-angioplasty/about/pac-20384761.

[6] *Merriam-Webster.com Dictionary*, "atherectomy," accessed May 25, 2022, https://www.merriam-webster.com/medical/atherectomy.

[7] *Merriam-Webster.com Dictionary*, "blood-bank," accessed June 27, 2022, https://www.merriam-webster.com/dictionary/blood%20bank.

[8] Medline Plus, Abdominal sounds (bowel sounds), accessed May 25, 2022, https://medlineplus.gov/ency/article/003137.htm.

[9] Mayo Clinic, "cardiac catheterization," accessed April 28, 2022, https://www.mayoclinic.org/tests-procedures/cardiac-catheterization/about/pac-20384695.

cardiac stent. A cardiac stent, looks like a tiny coil of wire mesh and is inserted during a percutaneous cardiac intervention to support the walls of a coronary artery and help prevent it from re-narrowing after the procedure.[10]

capacity. "The ability to hold, receive, store or accommodate."[11]

cardiologist. A cardiologist is a physician who practices "the study of the heart and its action and diseases."[12]

chronic obstructive pulmonary disease. "Chronic obstructive pulmonary disease is a chronic inflammatory lung disease that causes obstructed airflow from the lungs."[13]

colon. "The part of the large intestine that extends from the cecum to the rectum."[14]

community living center. CLCs are VA-owned facilities typically on or near VA property that provide long-term skilled-nursing care and may also offer short or long-term specialty programs.[15]

computerized tomography. "A computerized tomography (CT) scan combines a series of x-ray images from different angles around your body and uses computer processing to create cross-sectional images of the bones, blood vessels and soft tissues inside your body."[16]

coronary artery disease. "Coronary artery disease develops when major blood vessels that supply your heart become damaged or diseased."[17]

critical value. "Any diagnostic finding which must be acted upon by the ordering provider or their designee immediately or within a short window of time and could result in severe morbidity or mortality if left untreated. (Example: critically elevated Potassium)."[18]

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[10] Mayo Clinic, percutaneous coronary intervention "coronary angioplasty," accessed April 27, 2022, https://www.mayoclinic.org/tests-procedures/coronary-angioplasty/about/pac-20384761.

[11] *Merriam-Webster.com Dictionary,* "capacity," accessed April 23, 2022, https://www.merriam-webster.com/dictionary/capacity.

[12] *Merriam-Webster.com Dictionary,* "cardiology," accessed April 11, 2022, https://www.merriam-webster.com/dictionary/cardiologist.

[13] Mayo Clinic, "chronic obstructive pulmonary disease," accessed May 14, 2022, https://www.mayoclinic.org/diseases-conditions/copd/symptoms-causes/syc-20353679.

[14] *Merriam-Webster.com Dictionary*, "colon," accessed April 23, 2022 from https://www.merriam-webster.com/dictionary/colon.

[15] VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.

[16] Mayo clinic, "computerized tomography," accessed May 14, 2022, https://www.mayoclinic.org/tests-procedures/ct-scan/about/pac-20393675.

[17] Mayo Clinic, "coronary artery disease," accessed May 14, 2022, https://www.mayoclinic.org/diseases-conditions/coronary-artery-disease/symptoms-causes/syc-20350613.

[18] Fayetteville VA Coastal Healthcare System MCM 11-89.

diffuse. "Not concentrated or localized."[19]

disposition. The final arrangement or transfer of care.[20]

diverticulitis. Diverticulitis is when diverticula, which are "small, bulging pouches that can form in the lining of your digestive system," most often the colon, become inflamed or in some cases infected.[21]

duodenum. "The first part of the small intestine."[22]

echocardiogram. "An echocardiogram uses sound waves to produce images of your heart and allows a physician to see the heart beating and pumping blood."[23]

electrocardiogram. A diagnostic test that records the electrical signals in the heart and is used to detect problems or monitor the heart.[24]

gastroenterologist. A gastroenterologist is a physician who specializes in "a branch of medicine concerned with the structure, functions, diseases, and pathology of the stomach and intestines."[25]

general anesthesia. "General anesthesia brings on a sleep-like state with the use of a combination of medicines. The medicines, known as anesthetics, are given before and during surgery or other medical procedures. General anesthesia usually uses a combination of intravenous medicines and inhaled gasses."[26]

hemodynamic. Hemodynamic refers to "relating to or functioning in the mechanics of blood circulation."[27]

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[19] *Merriam-Webster.com Dictionary,* "diffuse," accessed April 23, 2022, https://www.merriam-webster.com/dictionary/diffuse.

[20] *Merriam-Webster.com Dictionary,* "disposition," accessed April 11, 2022, https://www.merriam-webster.com/dictionary/disposition.

[21] Mayo Clinic, "diverticulitis," accessed April 18, 2023, https://www.mayoclinic.org/diseases-conditions/diverticulitis/symptoms-causes/syc-20371758.

[22] *Merriam-Webster.com Dictionary,* "duodenum," accessed April 23, 2022, from https://www.merriam-webster.com/dictionary/duodenum.

[23] Mayo Clinic, "echocardiogram," accessed April 23, 2022, https://www.mayoclinic.org/tests-procedures/echocardiogram/about/pac-20393856.

[24] Mayo Clinic, "Electrocardiogram (ECG or EKG)," accessed April 18, 2023, https://www.mayoclinic.org/tests-procedures/ekg/about/pac-20384983.

[25] *Merriam-Webster.com Dictionary,* "gastroenterology," accessed April 23, 2022, https://www.merriam-webster.com/dictionary/gastroenterologist.

[26] Mayo Clinic, "general anesthesia," accessed March 16, 2023, https://www.mayoclinic.org/tests-procedures/anesthesia/about/pac-20384568.

[27] *Merriam-Webster.com Dictionary,* "hemodynamic," accessed June 27, 2022, https://www.merriam-webster.com/dictionary/hemodynamic.

hyperlipidemia. "The presence of excess fat or lipids in the blood."[28]

inflammation. "A local response to cellular injury that is marked by capillary dilatation, leukocytic infiltration, redness, heat, and pain and that serves as a mechanism initiating the elimination of noxious agents and of damaged tissue."[29]

intensivist. "An intensivist is a specially trained critical care medical professional."[30]

intravenous. Situated, performed, or occurring within a vein.[31] Example: An intravenous infusion of fluid.

median. "Applies to the value that represents the point at which there are as many instances above as there are below."[32]

myocardial infarction. "A myocardial infarction (heart attack) occurs when the flow of blood to the heart is severely reduced or blocked. A lack of blood flow can damage or destroy parts of the heart muscle."[33]

nephrology. "A branch of medicine concerned with the kidneys."[34]

omentum. "A fold of peritoneum connecting or supporting abdominal structures (such as the stomach and liver)."[35]

peritoneum. "The smooth transparent serous membrane that lines the cavity of the abdomen of a mammal and is folded inward over the abdominal and pelvic viscera."[36]

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[28] *Merriam-Webster.com Dictionary,* "hyperlipidemia," accessed May 14, 2022, from https://www.merriam-webster.com/dictionary/hyperlipidemia.

[29] *Merriam-Webster.com Dictionary,* "inflammation," accessed May 25, 2022, https://www.merriam-webster.com/dictionary/inflammation.

[30] Mayo Clinic, "critical care," accessed June 7, 2022, https://www.mayoclinic.org/departments-centers/critical-care/sections/overview/ovc-20399554.

[31] *Merriam-Webster.com Dictionary,* "intravenous," accessed May 25, 2022, https://www.merriam-webster.com/dictionary/intravenous.

[32] *Merriam-Webster.com Dictionary*, "median," accessed March 21, 2023, https://www.merriam-webster.com/dictionary/median.

[33] Mayo Clinic, "heart attack," accessed May 25, 2022, https://www.mayoclinic.org/diseases-conditions/heart-attack/symptoms-causes/syc-20373106.

[34] *Merriam-Webster.com Dictionary,* "nephrology," accessed April 23, 2022, https://www.merriam-webster.com/dictionary/nephrology.

[35] *Merriam-Webster.com Dictionary,* "omentum" accessed April 24, 2022, https://www.merriam-webster.com/dictionary/omentum.

[36] *Merriam-Webster.com Dictionary,* "peritoneum," accessed May 25, 2022, https://www.merriam-webster.com/dictionary/peritoneum.

pneumoperitoneum. A pneumoperitoneum is free air within the peritoneal cavity. It could be an indication of a perforation of the gastrointestinal tract including a colon perforation.[37]

pulmonary fibrosis. "Pulmonary fibrosis is a lung disease that occurs when lung tissue becomes damaged and scarred."[38]

premature ventricular contractions. "Premature ventricular contraction (PVCs) are extra heartbeats that begin in one of the heart's two lower pumping chambers (ventricles). These extra beats disrupt the regular heart rhythm, sometimes causing a sensation or fluttering or a skipped beat in the chest." [39]

psychiatry. "A branch of medicine that deals with the science and practice of treating mental, emotional, or behavioral disorders."[40]

rebound. During physical inspection of the patient's abdomen, "rebound tenderness is the elicitation of tenderness by rapidly removing the examining hand."[41]

troponin. "Troponin is a type of protein found in the muscles of your heart. Troponin isn't normally found in the blood" unless heart muscle is damaged. It is a blood test to help providers determine if you are having or have recently had a heart attack.[42]

turnaround time. Turnaround time is the time it takes for something (such as a test result) "to be received, processed, and returned."[43]

virtual. An existing or occurring appointment primarily online.[44]

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[37] Ramponi, Denise R. DNP, FNP-C, ENP-BC, FAEN, FAANP, CEN Pneumoperitoneum, Advanced Emergency Nursing Journal: April/June 2018 - Volume 40 - Issue 2 - p 87-93.

[38] Mayo Clinic. "pulmonary fibrosis," accessed May 14, 2022, https://www.mayoclinic.org/diseases-conditions/pulmonary-fibrosis/symptoms-causes/syc-20353690.

[39] Mayo Clinic. "premature ventricular contractions," accessed May 19, 2022, https://www.mayoclinic.org/diseases-conditions/premature-ventricular-contractions/symptoms-causes/syc-20376757.

[40] *Merriam-Webster.com Dictionary,* "psychiatry," accessed April 24, 2022, https://www.merriam-webster.com/dictionary/psychiatry.

[41] CM Ferguson. "Inspection, Auscultation, Palpation, and Percussion of the Abdomen*,"* Clinical Methods: The History, Physical and Laboratory Examinations, 3rd ed., eds. HK Walker, WD Hall, and JW Hurst (Boston: Butterworths, 1990), Chapter 93, 1990, accessed May 25, 2022, https://www.ncbi.nlm.nih.gov/books/NBK419/?report=reader.

[42] National Library Medicine, Medline Plus, "troponin," accessed June 9, 2022, https://medlineplus.gov/lab-test/troponin-test.

[43] *Merriam-Webster.com Dictionary,* "turnaround," accessed May 25, 2022, https://www.merriam-webster.com/dictionary/turnaround.

[44] *Merriam-Webster.com Dictionary,* "virtual," accessed June 8, 2022, https://www.merriam-webster.com/dictionary/virtual.

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