

Memorandum to the File - Administrative Closure

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Delay of Inter-Facility Transfer
William S. Middleton Memorial Veterans Hospital
Madison, Wisconsin
MCI: 2010-00348-HI-0227

12/10/09

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an evaluation in response to allegations that staff at a community hospital could not contact either the transfer coordinator (TC) or a physician at the VA Medical Center (the medical center) in Madison, Wisconsin, regarding an inter-facility transfer. The purpose of this review was to determine if the allegation had merit.

Background.

The medical center provides medical, surgical, neurological, and mental health services. It operates 87 beds and provides services at five community based outpatient clinics located in Baraboo, Janesville, and Beaver Dam, Wisconsin, and Rockford and Freeport, Illinois. The medical center is affiliated with the University of Wisconsin's School of Medicine and Public Health and provides training for residents and other allied health professions. The medical center is part of Veterans Integrated Service Network (VISN) 12.

(b)(3): 5 U.S.C. App 3 IG Act

the complainant contacted the OIG Hotline and alleged difficulty with an inter-facility transfer from a community hospital to the medical center. He specifically alleged that:

- He contacted the medical center (b)(3): 5 U.S.C. App 3 IG Act and asked to speak to the TC. He was told that the coordinator was not available until 8:00 a.m.
- He asked a clerk to again contact the medical center at 8:00 a.m. so that he could speak to the Medical Officer of the Day (MOD) and was told there was no one to talk to and no doctor was on call.

Results.

(b)(3): 5 U.S.C. App 3 IG Act

We contacted the complainant, (b)(3): 5 U.S.C. App 3 IG Act in the emergency department of a community hospital, by telephone to conduct an interview. He stated that he wanted to transfer a veteran and contacted the medical center and asked to speak to the TC. He was told that the TC would not be on duty until 8:00 a.m. He then asked a clerk to again contact the medical center after 8:00 a.m. and stated he would talk to the MOD if needed. The clerk was told that there wasn't anyone to speak to nor was there a MOD. He then told the clerk to contact the medical center a third time and he wanted to speak to the "CEO" or the nursing supervisor. He told us that he was going off duty and did not want to wait around until someone became available at the medical center to accept the transfer. Staff from the community hospital contacted the medical center a third time, and the physician was able to talk to a clinician and arrange the inter-facility transfer.

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The complainant told us he could not recall the name of the veteran, his diagnosis or the date of the event. He told us that he would review inter-facility transfer logs and attempt to identify the name of the veteran and also search for any related emails that he might have sent. We provided our contact information to him, and he agreed to contact us if he found any additional information.

We did not receive any additional information. We attempted to contact the complainant a second time; however, he was unavailable and did not return our telephone call. We then asked the medical center to provide us with a list of inter-facility transfers for the 6 months prior to the complaint. We reviewed the medical records of seven veterans transferred from the complainant's facility. None of the relevant transfer progress notes identified the complainant as the transferring physician.

The local medical center MOD policy indicates physician coverage is available 24 hours a day, 7 days a week, and the MOD is responsible for accepting inter-facility transfers. Additionally, the local medical center transfer policy states that the admission coordinator or administrative officer of the day is the main point of contact for inter-facility transfers.

Conclusions.

The complainant did not provide us with sufficient information to fully review the allegation. The medical center has policies which define inter-facility procedures and responsibilities 24 hours a day, 7 days a week.

This case does not warrant further review at this time and can be closed without the issuance of a formal report.

Prepared by: //es//
Susan Zarter
Associate Director, Atlanta Region
Office of Healthcare Inspections

Reviewed by: //es//
Verena Briley-Hudson
Director, Chicago Region
Office of Healthcare Inspections