



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Alleged Mismanagement of
Inpatient Care at the
Colmery-O'Neil VA Medical
Center within the VA Eastern
Kansas Health Care System
Topeka, Kansas



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection regarding an anonymous complainant's allegations of inappropriate and mismanaged inpatient care at the Colmery-O'Neil VA Medical Center (Facility), Topeka, Kansas. The Facility is one of two medical centers¹ governed by the VA Eastern Kansas Health Care System (System). The specific allegations were

- Physicians were practicing beyond their scope of practice (clinical privileges)² and expertise, and failed to seek assistance from specialists, thus placing patients at risk; and³
- The entire inpatient medical service was covered by a Nurse Practitioner (NP) without any help or supervision.

The OIG did not substantiate that physicians were practicing beyond their clinical privileges and expertise. However, two providers were granted clinical privileges for the System rather than specific to the Facility. OIG staff determined that a surgeon and a hospitalist were granted clinical privileges for procedures that exceeded the Facility's operative and intensive care unit (ICU) complexity levels, respectively.⁴ However, these procedures had not been performed at the Facility.

The OIG did not substantiate that physicians failed to seek assistance from specialists, thus patients were not placed at risk. The OIG found that the four identified patients were referred to specialists as needed. However, OIG staff found that specialty care provider staffing levels⁵ and the specialists' limited hours of availability resulted in delays, increased lengths of stay, and patient transfers. At the time of OIG's onsite visit, the Facility did not have Memoranda of Understanding with non-VA hospitals or service/care coordination agreements between Facility

¹ The System's second medical center, Dwight D. Eisenhower VA Medical Center, is located in Leavenworth, KS.

² In this report, the OIG uses the term clinical privileges, instead of scope of practice, when discussing physicians.

³ In this report, the OIG considers risk to be the potential for an adverse event or close call recurrence.

⁴ Hospitalists are inpatient providers and include physicians, NPs, and physician assistants; VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012; VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.

⁵ In this report, the OIG uses the term staffing levels to indicate provider full time employee equivalents.

specialists and hospitalists.⁶ Since the onsite visit, OIG staff received a Memorandum of Understanding signed by the System Director but not the non-VA hospital administrator, and another Memorandum of Understanding and a Cardiology Service Agreement were initiated in July 2017.

The patients OIG staff reviewed were transferred to a higher level of care if the patients' health care requirements exceeded a physician's clinical privileges or expertise.

OIG staff reviewed the electronic health records of 100 Facility inpatients transferred to another VA or non-VA facility and found that specialty services' consults were ordered when medically necessary; the patients' transfers were timely and clinically indicated; and because of the limited hours of specialty coverage, inpatients were transferred if the specialist was unavailable.⁷

OIG staff also reviewed the electronic health records of 47 Facility inpatients who died between April 1, 2016, and March 31, 2017, and determined that the 47 inpatients' deaths were associated with terminal end-stage disease rather than delays in consults or specialty services.

The OIG did not substantiate that an NP was covering the entire inpatient medical service without any help or supervision. The NP usually worked with a physician hospitalist, and an assigned physician was available by telephone consultation if a physician was not physically available. The OIG found that hospitalists provided inpatient medical service coverage 24 hours a day, seven days a week.

The OIG also found that the NP was acting within his/her scope of practice for VA employment and did not require physician supervision. Prior to January 13, 2017, Facility NPs worked under the State of Kansas' Nurse Practice Act requirements.⁸ On January 13, 2017, VA implemented new regulations permitting full practice authority for Advanced Practice Registered Nurses (APRN).⁹ NPs are not required to be supervised by a physician if they are practicing within the scope of their established responsibilities.

⁶ VHA Directive 2008-056; *VHA Consult Policy*, September 16, 2008. This directive was in effect at the time of some of the events discussed in this report; it expired September 30, 2013, and was replaced by VHA Directive 1232(1), *Consult Processes and Procedures*, August 24, 2016. The 2008 directive uses the term service agreement and the 2016 directive uses the term care coordination agreement to describe a written agreement between two services that defines their work flow rules, is mutually agreed upon, and signed by the participating service chiefs.

⁷ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. Adverse events are untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within a facility; Health System Policy Memorandum, NO. 00B-21, *Patient Transfers*, September 3, 2015

⁸ Senate Bill (SB) 69. Session 2015. State of Kansas.; Kansas State Board of Nursing, Nurse Practice Act, July 2015 (revised April 2016); Kansas Office of Revisor of Statutes. 65-1130. Advanced practice registered nurse; standards and requirements for licensure; rules and regulations; roles, titles and abbreviations; prescription of drugs authorized; licensure of currently registered individuals.

⁹ APRNs include NPs, Clinical Nurse Specialists, and Certified Nurse-Midwives; 38 CFR § 17.415; Full Practice Authority for Advanced Practice Registered Nurses. January 2017.

In March 2017, the Veterans Health Administration (VHA) determined that facilities' medical staff bylaws should be amended to recognize APRNs as Licensed Independent Practitioners.¹⁰ The System's bylaws had not been modified to be compatible or compliant with 38 CFR 17.415, Full Practice Authority for APRNs and The Joint Commission requirements.¹¹

OIG staff also determined that the Facility was not meeting VHA requirements related to surgical complexity designations and Emergency Department (ED) specialty service coverage. The Facility was designated as a standard operative complexity but did not comply with all criteria for this designation, including after-hours requirements for surgeon staffing, pre-operative risk and anesthesia assessments, or anesthesia service coverage.¹² Staff stated that patients awaiting admission or inpatients who required surgery after-hours were either diverted or transferred to a non-VA facility.

In addition, specialty care clinics had only one provider for coverage during the day shift. The Facility ED and inpatient services did not have an after-hours specialty service on-call schedule, and the Facility did not have after-hours ultrasound coverage.

The OIG made six recommendations to the System Director related to providers' clinical privileges; bylaw updates; requirements for after-hours surgeon staffing, pre-operative risk and anesthesia assessments, and anesthesia service coverage; specialty care consults' timeliness; on-call specialists' availability; and timely ED specialty resources.

Comments

The Veterans Integrated Service Network and System Directors concurred with the OIG recommendations and provided acceptable action plans. (See Appendixes A and B, pages 26–30, for the Directors' comments.) Based on information provided, the OIG considers Recommendation 2 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.



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¹⁰ VA APRN Full Practice Authority, Facility Implementation Briefing. March 2017.

¹¹ 38 CFR § 17.415. Full Practice Authority for Advanced Practice Registered Nurses. January 2017; VA APRN Full Practice Authority, Facility Implementation Briefing. March 2017; The Joint Commission, MS 01.01.01.

¹² VHA Directive 2010-018.

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Abbreviations

APRN	advanced practice registered nurse
CRNA	certified registered nurse anesthetist
DNR	do not resuscitate
ED	emergency department
EGD	esophagogastroduodenoscopy
EHR	electronic health record
EKG	electrocardiogram
Facility	Colmery-O'Neil VA Medical Center
FPA	full practice authority
HSPM	Health System Policy Manual
ICU	intensive care unit
IV	intravenous
MEB	medical executive board
MOU	memorandum of understanding
NP	nurse practitioner
OIG	Office of Inspector General
PCU	progressive care unit
System	VA Eastern Kansas Health Care System
Tele-ICU	telemedicine services
UCC	urgent care clinic
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to an anonymous complainant's allegations regarding inappropriate and mismanaged inpatient care at the Colmery-O'Neil VA Medical Center (Facility), Topeka, Kansas.

Background

The VA Eastern Kansas Health Care System (System) is composed of two medical centers, the Facility and the Dwight D. Eisenhower VA Medical Center (Leavenworth) in Leavenworth, Kansas. The System is part of Veterans Integrated Service Network (VISN) 15 and serves veterans in eastern Kansas and northwestern Missouri. The System has 557 operating beds that include 138 long-term care beds and a 202-bed domiciliary.

The System operates seven community based outpatient clinics in eastern Kansas located in Chanute, Emporia, Fort Scott, Garnett, Junction City, Kansas City, and Lawrence. The System also has clinics in northwestern Missouri located in Platte City and St. Joseph. The System offers inpatient and outpatient services with a focus on primary care, psychiatric treatment, and extended care.

Facility Designations

The Facility's complexity level is designated as 1c-Mid-High. The operative complexity is standard. The Intensive Care Unit (ICU) is a Level 4.¹³

Facility Complexity Designation

The Veterans Health Administration (VHA) Facility Complexity Model was first adopted for use in 1989 and is updated every three years. The facility groupings are used for various peer grouping purposes, including operational reporting, performance measurement, research studies, and establishing pay levels for senior leadership.¹⁴

VHA defines a 1c-Mid-High complexity facility as one with a medium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs. It falls in the middle of the five categories of facility complexity.

¹³ The most recent VA model is the fiscal year 2014 model, which was approved and signed by the Under Secretary for Health on March 25, 2015.

¹⁴ VHA Office of Productivity, Efficiency, and Staffing, *Facility Complexity Level Model Fact Sheet*.

The Facility is designated as a 1c-Mid-High complexity and is organized under a single leadership team that provides oversight for the System, which includes two medical centers. Two non-VA hospitals are within four miles of the Facility, Leavenworth is 64 miles away, and the Kansas City VA Medical Center is 72 miles away. The Facility and Leavenworth are considered combined for determining their facility complexity designations.

Operative Complexity Designation

VHA assigns all of its inpatient medical centers an operative complexity level of standard, intermediate, or complex. Surgical procedures are assigned to one of three operative complexity levels (standard, intermediate or complex), and are designed to establish policy and guidance regarding the infrastructure requirements in relationship to the complexity of surgical procedures performed. The Facility is designated as a standard operative complexity, which requires the least facility infrastructure and has the simplest surgical procedures.¹⁵ Leavenworth is designated as an intermediate operative complexity.

ICU Complexity Designation

VHA defines four levels of intensive care. These levels were closely related to levels of academic affiliation with the high levels (Levels 1 and 2) associated with tertiary care, academic medical centers. VHA has a number of small, often rural, non-tertiary hospitals that provide acute services, making it necessary to identify an additional level of intensive care as compared to the private sector.¹⁶ These smaller, more rural VHA hospitals are comparable to non-VA critical-access hospitals.¹⁷ A Level 4 ICU provides basic services that include a very limited subset of specialists and subspecialists by referral, limited pharmacy “core hours,” limited laboratory services, and limited diagnostic and therapeutic radiologic procedures.¹⁸ The Facility has a Level 4 ICU.

Emergency Department

According to VHA, an Emergency Department (ED) is a unit in a VA medical facility that has acute care medical and/or surgical inpatient beds and whose primary responsibility is to provide

¹⁵ VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010. This directive expired May 31, 2015, and has not been recertified or replaced.

¹⁶ Tertiary hospitals are hospitals where patients may be referred for specialty services and treatment. https://www.hopkinsmedicine.org/patient_care/pay_bill/insurance_footnotes.html. (The website was accessed on May 22, 2017.)

¹⁷ Critical access hospitals are rural hospitals designated by states that have a medical rural flexibility program, maintain no more than 25 inpatient beds, and have an average length of stay of 96 hours or less. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/CAHs.html>. (The website was accessed on May 22, 2017.)

¹⁸ Almenoff P. Sales A, et al. Intensive Care Services in the Veterans Health Administration. *Chest* (132). November 2007:1455-1462.

resuscitative therapy and stabilization in life-threatening situations. Emergency care is provided 24 hours a day, 7 days a week.¹⁹

Critical Care Medicine

The System has a Memorandum of Understanding (MOU) with the Minneapolis VA Health Care System, Minnesota, for critical care telemedicine services (Tele-ICU). Tele-ICU services include direct real-time visualization of the patient in an ICU or Progressive Care Unit (PCU) room via live two-way reciprocal video feed, electronic monitoring and chart review, consulting, prescribing, rendering a diagnosis, ordering tests or procedures, and/or providing interpretation to a patient or patient's family.²⁰ Patients in the Facility ICU were automatically connected to the live two-way reciprocal video feed and electronic monitoring. Tele-ICU physicians were licensed, credentialed, and privileged to practice critical care telemedicine in the monitored facility. Tele-ICU physicians are required to document interventions in the patient's electronic health record (EHR). These services were available to supplement ICU care provided by the Facility hospitalists.

Facility Hospitalists' Coverage

Hospitalists are inpatient providers and include physicians, nurse practitioners (NP), and physician assistants who provide comprehensive care to hospitalized patients. This care includes diagnosis, treatment, and the performance of medical procedures. Hospitalists employ quality and process improvement techniques, collaboration, communication, and coordination with physicians and healthcare personnel, efficient use of hospital and healthcare resources, and the safe transitioning of patient care within the hospital, and from the hospital to the community.²¹ Hospitalists at the Facility provide inpatient care with the support of specialty care as needed and when available. Included in the definition of a hospitalist is a nocturnist, a physician who works overnight.

The Facility generally schedules two hospitalists who work the day shift with a physician and a physician assistant who cover the day shift for seven days, alternating with a physician and an NP who cover the next seven days. Two nocturnists, who work alternating seven nights on and seven nights off, cover the night shift.²²

¹⁹ VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016, (amended March 7, 2017).

²⁰ The progressive care unit is considered to be a step down ICU unit at the facility.

²¹ Society of Hospital Medicine. *Definition of a Hospitalist and Hospital Medicine*. January 26, 2016. https://www.hospitalmedicine.org/Web/About_SHM/Hospitalist_Definition/About_SHM/Industry/Hospital_Medicine_Hospital_Definition.aspx?hkey=fb083d78-95b8-4539-9c5b-58d4424877. (The website was accessed on May 12, 2017.)

²² The day shift is from 7:00 a.m. to 7:00 p.m.; the night shift is from 7:00 p.m. to 7:00 a.m.

Clinical Consults

A clinical consult is a two way communication entered into the EHR on behalf of a provider who requests an opinion, advice, or expertise regarding evaluation or management of a patient's specific problem from another provider.²³ A consult will be entered when a provider, such as a hospitalist, requests the services of a specialist.

Credentialing and Privileging

According to VHA Handbook 1100.19,²⁴ credentialing and privileging are defined as follows:

Credentialing refers to the systematic process of screening and evaluating qualifications and other credentials, including, but not limited to: licensure, required education, relevant training and experience, and current competence and health status.

Clinical privileging is defined as the process by which a practitioner, licensed for independent practice, is permitted by law and the facility to practice independently, to provide specified medical or other patient care services within the scope of the individual's license based on the individual's clinical competence as determined by peer references, professional experience, health status, education, training, and licensure.

VHA requires that providers' clinical privileges are facility-specific, practitioner-specific, and within available resources.²⁵

Allegations

On February 27, 2017, the OIG received allegations from an anonymous complainant:

1. Physicians were practicing beyond their scope of practice (clinical privileges)²⁶ and expertise, and failed to seek assistance from specialists, thus placing patients at risk.²⁷

²³ VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008. This directive was rescinded and replaced by VHA Directive 1232 (1), *Consult Processes and Procedures*, August 23, 2016 (amended on September 23, 2016). Both directives contain similar language regarding consult processes.

²⁴ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

²⁵ VHA Handbook 1100.19.

²⁶ The anonymous complainant was not available to clarify the term "scope of practice." While scope of practice is used for physician assistants and NPs, it is not commonly used to describe physicians' practice. In this report, the OIG uses the term clinical privileges instead of scope of practice when discussing physicians.

²⁷ Risk is the vulnerability of the system and the potential contributions to the adverse event or close call.

2. The entire inpatient medical service was covered by an NP without any help or supervision.

The anonymous complainant provided the names of four patients as support for the allegations.

Scope and Methodology

The OIG initiated a healthcare inspection in March 2017 and conducted a site visit April 18–20, 2017.

OIG staff interviewed the System Director, Chief of Staff, and the Acting Director of Human Resources. OIG staff interviewed Facility hospitalists and specialists in cardiology, emergency care, neurology, palliative care, and surgery. OIG staff interviewed a Tele-ICU physician and a Tele-ICU nurse. Additionally, OIG staff interviewed the VHA National Director of Surgery, a Leavenworth cardiologist, and the VISN 15 Chief Medical Officer and Quality Management Officer.

OIG staff reviewed relevant VHA, VISN, System, and Facility policies; relevant medical literature; and Facility data. OIG staff reviewed documents related to credentialing and privileging, consults, and hospitalist coverage schedules between January 1, 2016, and April 17, 2017. OIG staff reviewed EHRs of the four patients identified by the complainant (see Case Summaries, page 7). OIG staff also reviewed the EHRs of all Facility inpatients who died or were transferred to another VA or non-VA facility between April 1, 2016, and March 30, 2017, to determine

- If consults for specialty services were ordered and provided at the Facility,
- Why patients were required to transfer to another VA or non-VA Facility,
- If transfers were clinically indicated, and
- If a delay in consults or receipt of specialty services were a contributing factor to a patient's death.

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

The OIG substantiate allegations when the facts and findings support that the alleged events or actions took place. The OIG do not substantiate allegations when the facts show the allegations are unfounded. The OIG cannot substantiate allegations when there is no conclusive evidence to either sustain or refute the allegation.

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.

Case Summaries

Patient A

In 2016, Patient A, a veteran with non-operable valvular heart disease, hypertension, and chronic renal failure, presented to the Facility's ED. The patient complained of eating and drinking small amounts for the past six days and lost 15 pounds over the past four months. His vital signs, abdominal examination, and chest x-ray were normal. Patient A was discharged home with an outpatient gastroenterology consult and recommendation for follow-up with his primary care provider.

The following month, Patient A returned to the ED due to a general decline in his condition. A computerized tomography scan of the abdomen revealed gallstones.²⁸ Hospitalist A admitted the patient for dehydration, further evaluation, and care. Hospitalist A requested a gastroenterology consult.²⁹

The next day, the gastroenterologist evaluated the patient for difficulty swallowing, vomiting, and weight loss. The gastroenterologist performed an esophagogastroduodenoscopy (EGD) to evaluate the patient's symptoms.³⁰ A Certified Registered Nurse Anesthetist (CRNA) assessed the patient prior to the EGD and provided intravenous (IV) sedation.³¹ The patient's last electrocardiogram (EKG) had been completed in May 2016.³² The CRNA assessed the patient as having an American Society of Anesthesiologists score of 3, which categorized the patient as having severe systemic disease.³³ With the EGD, the gastroenterologist determined the patient had non-bleeding ulcers and inflammation in the stomach.³⁴ At the end of the procedure, the

²⁸ Gallstones are solid material that forms in the gallbladder or common bile duct. U.S. National Library of Medicine. PubMed Health. <https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0018967/>. (The website was accessed on May 30, 2017.)

²⁹ A gastroenterologist is a physician who has training and experience in the management of disease of the gastrointestinal tract and liver. This includes study of the esophagus, stomach, small intestine, colon and rectum, pancreas, gallbladder, bile ducts, and liver. American College of Gastroenterology. *What is a Gastroenterologist?* <http://s3.gi.org/patients/ccrk/WhatIsAGastro.pdf>. (The website was accessed on May 15, 2017.)

³⁰ EGD is a procedure in which a practitioner uses an endoscope (a flexible tube with a light and camera at the end) to examine the lining of the esophagus, stomach, and first part of the small intestine. U.S. National Library of Medicine. Medline Plus. <https://medlineplus.gov/ency/article/003888.htm>. (The website was accessed on May 15, 2017.)

³¹ Intravenous sedation is the administration of medicines to sedate the patient given through a needle or tube inserted into a vein. U.S. National Library of Medicine. Medline Plus. <https://medlineplus.gov/ency/article/002383.htm>. (The website was accessed on May 15, 2017.)

³² An EKG is a test that records the electrical activity of the heart.

³³ An American Society of Anesthesiologists Score is a widely used classification/grading system for preoperative health of surgical patients in various locations. U.S. National Library of Medicine. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3106380/>. (The website was accessed on June 1, 2017.)

³⁴ Gastritis occurs when the lining of the stomach becomes inflamed or swollen. U.S. National Library of Medicine. Medline Plus. <https://medlineplus.gov/ency/article/001150.htm>. (The website was accessed on May 15, 2017.)

patient developed a slow heart rate that did not respond to medications. The patient had a cardiac arrest; a Code Blue was called; and the patient was resuscitated, intubated, and transferred to the ICU.³⁵

Hospitalist A ordered an EKG that revealed evidence of ischemia to the heart. Hospitalist A continued medical support for the patient's ulcers, continued IV sedation, and consulted with Respiratory Therapy staff to wean the patient off the ventilator.

The IV sedation was discontinued approximately four hours after the patient was transferred to the ICU. The respiratory therapist removed the patient from the ventilator about an hour and a half later. Hospitalist A spoke with family members to clarify the patient's code status and documented, "They want everything done and thus if he codes again, we will proceed with intubation."

Patient A had another cardiopulmonary arrest approximately one hour after ventilator removal. Hospitalist A resuscitated, re-intubated, and placed the patient back on the ventilator. During resuscitation, the Tele-ICU physician evaluated the situation but offered no further recommendations. Hospitalist A again discussed the patient's condition with the family. The family agreed to continue mechanical ventilation but did not wish further interventions if the patient's clinical status declined. Hospitalist A changed the patient's status to do not resuscitate (DNR).

Two days later, Hospitalist A discussed with the family the unavailability of a cardiologist and pulmonologist at the Facility and offered to transfer the patient to a higher level of care at a non-VA facility; the family declined the transfer. Hospitalist A documented that during that week, the Facility had no coverage for cardiology or pulmonology physicians. A social worker met with Hospitalist A and family members when the patient's critical illness was discussed.

Two days later, Hospitalist A documented, "There is no role for palliative care as the family is not close to letting go at this point."³⁶ A cardiologist at another VA facility reviewed Patient A's echocardiogram with Hospitalist A, and indicated a decline in heart function.³⁷ Hospitalist A documented that he would attempt to wean the patient from the ventilator, and if not successful, consult with a palliative care provider. Hospitalist A requested a cardiology consult for assistance in managing cardiac issues and a pulmonary consult for ventilator management. For

³⁵ Code Blue is an announcement used to summon immediate help when a patient is in cardiac/respiratory arrest; resuscitated is a term that means to revive a patient from apparent death or from unconsciousness; Intubated refers to endotracheal intubation which is a medical procedure in which a tube is placed into the windpipe (trachea) through the mouth or nose. U.S. National Library of Medicine. <https://medlineplus.gov/ency/article/003449.htm>. (The website was accessed on May 15, 2017.)

³⁶ The Facility has a palliative care physician who is available Monday–Friday, 8:00 a.m.–4:30 p.m.

³⁷ An echocardiogram is a test that uses sound waves to create moving pictures of your heart. *National Heart, Lung, and Blood Institute*. What is Echocardiography? <https://www.nhlbi.nih.gov/health/health-topics/topics/echo/>. (The website was accessed on May 15, 2017.)

approximately a week following the patient's second admission, EHR documentation reflected eight conversations between the hospitalist and the family that indicated the family's wishes regarding the patient's care. Weaning the patient off the ventilator was not successful.

Seven days after Patient A's second admission, Hospitalist B assumed care of the patient. The cardiologist responded to the initial consult three days after it was made and recommended conservative care. The pulmonologist was off-site and not available to see the patient, but discussed the care with Hospitalist B, and recommended palliative care, withdrawal of care, and extubation due to his condition.³⁸ Hospitalist B consulted the neurologist and palliative care physician. The family chose withdrawal of care and removal from the ventilator. The patient was extubated and died with family members present.

Patient B

In late 2016, Patient B, a veteran with chronic obstructive pulmonary disease requiring home oxygen, prior strokes with right-sided weakness, and seizures, was brought to the Facility's ED by his family after he became unresponsive at home. The patient's spouse stated the patient had nausea and "dry heaves" but had been at his baseline mental status. He became unresponsive at home but was breathing and had a pulse. In the ED, the physician intubated the patient for airway protection (no gag reflex) and subsequently transferred the patient to a non-VA Facility for a higher level of care. There, the patient received antibiotics for sepsis from a urinary tract infection, respiratory therapy, and a pulmonary consult for respiratory failure.

The following week, at the non-VA facility, a palliative medicine and supportive care physician evaluated the patient. The physician stated that the family wanted to continue antibiotics and supportive care but requested DNR status for the patient. The patient was extubated that day.

Two days later, Patient B transferred back to the Facility, as requested by the family, for palliative care and was placed in the PCU.³⁹ Hospitalist A verified the patient's DNR status.

The following day, Hospitalist A noted that Patient B developed respiratory failure, a rapid heart rate of 180 beats per minute, and a fever of 102 degrees Fahrenheit. Hospitalist A discussed goals of care with the patient and family. Hospitalist A documented that although the family did not want the patient intubated, they did not want to withdraw treatment or have palliative care; therefore, Hospitalist A ordered radiologic and laboratory studies, and started antibiotics and medications for the patient's rapid heart rate, pain, and anxiety.⁴⁰ Hospitalist A consulted the cardiologist because the patient had elevated troponins, a blood test which indicated a possible heart attack.

³⁸ Extubation is the removal of an endotracheal tube from the patient

³⁹ The progressive care unit is considered to be a step down ICU unit at the facility.

⁴⁰ Palliative care is the treatment for a patient's discomfort, symptoms, and stress of serious illness.

The next day, the PCU registered nurse notified the respiratory therapist and the nocturnist, and initiated a Tele-ICU consult because of the patient's shortness of breath and decreased oxygenation levels. The nurse documented that the Tele-ICU consultant recommended continuing the patient's Patient Controlled Analgesia pump although there was no written consultant note from the Tele-ICU consultant.

One day later, Hospitalist A ordered an echocardiogram, as well as cardiology, pulmonary, and infectious disease consults. The patient also received blood transfusions. The patient developed a deep venous thrombosis (clot) in his right arm requiring anticoagulation medication. The PCU nurse requested a central venous line to provide access for multiple medication infusions. Hospitalist A placed a central venous line into the left internal jugular vein. This resulted in a pneumothorax (collapsed lung), which is a known risk factor for an insertion of a central line near the lung.⁴¹ Hospitalist C placed a chest tube to inflate the collapsed lung.⁴²

The next day, the cardiologist examined the patient and made no new recommendations. Hospitalist B assumed care of the patient and requested a palliative care consult. The palliative care physician evaluated the patient and met with the family, Hospitalist B, and a social worker. After the meeting, the palliative care physician initiated comfort measures and discharge planning for home hospice. Hospitalist B cancelled the infectious disease and pulmonary consults. The patient died later that day.

Patient C

In 2016, Patient C, a veteran with a history of prostate cancer 24 years earlier, presented to the Facility's ED with less than one day of nausea and vomiting. The family reported the patient was in good general health. His physical examination did not reveal abdominal pain or distension. The patient's EKG showed a new abnormal heart rhythm. Chest and abdominal x-rays did not reveal a cause for his symptoms. Laboratory studies were normal except for elevated blood glucose. The nocturnist admitted the patient to the medical unit with telemetry for gastroenteritis and monitoring of the abnormal heart rhythm.⁴³ The patient requested to be a full code.⁴⁴ The

⁴¹ Pneumothorax is an abnormal presence of air in the pleural cavity (which is a thin layer of tissue that covers the lung and lines the interior of the chest cavity). U.S. National Library of Medicine. PubMed Health. <https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0023382/>. (The website was accessed on May 15, 2017.)

⁴² A chest tube is a flexible plastic tube that is inserted through the chest wall and into the pleural space; it is used to remove air in the case of a pneumothorax. Zisis C, Tsirgogianni K, Lazaridis G, et al. Chest drainage systems in use. *Annals of Translational Medicine*. 2015;3(3):43. doi:10.3978/j.issn.2305-5839.2015.02.09. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4356865/>. (The website was accessed on May 15, 2017.)

⁴³ Gastroenteritis is an inflammation of the lining of the intestines caused by a virus, bacteria or parasites. U.S. National Library of Medicine. MedlinePlus. <https://medlineplus.gov/gastroenteritis.html>. (The website was accessed on May 15, 2017.)

⁴⁴ Full code is a term used to indicate a patient wants everything possible done to prolong his or her life. <http://content.healthaffairs.org/content/24/5/1311.full.pdf+html>. (The website was accessed on May 15, 2017.) P.1311 preface.

patient developed low blood oxygen levels and was transferred to the PCU for closer monitoring and treatment. The Tele-ICU service monitored the patient when the patient was admitted to the PCU. The Tele-ICU physician made no new recommendations. In the morning, Hospitalist A assessed the patient, started IV fluids, continued oxygen therapy, treated the abnormal heart rhythm, and ordered a computerized tomography scan of the chest. Hospitalist A discussed the plan of care and code status with the patient's family who reconfirmed the full code request. A chest computerized tomography scan revealed pneumonia on the left side of the chest. Hospitalist A determined that the patient had aspiration pneumonia, started IV antibiotics, and discussed the findings and plan of care with the patient's family. The family requested that the patient remain a full code and allow time for the antibiotic therapy to work. When the patient's condition deteriorated later that evening, the nocturnist again discussed the patient's plan of care with the family members. The family agreed to have the patient temporarily placed on a ventilator for respiratory support but did not want additional life support.

The next day, Hospitalist B assumed care for the patient and requested a palliative care consult; the palliative care physician evaluated the patient, and discussed the plan of care with the family. The patient was placed on hospice care and died later that day.

Patient D

In 2017, Patient D, a veteran with liver disease, presented to the ED complaining of shortness of breath, abdominal pain, and jaundice. He was transferred to a non-VA facility for a higher level of care due to his renal failure, end stage liver disease, and anemia. A little over two weeks later, at the non-VA facility, a palliative medicine and supportive care consultation was completed. The patient and his brother agreed to transfer the patient to the Facility for comfort and hospice care.

That same day, Hospitalist A evaluated the patient and noted that the patient appeared jaundiced with ascites.⁴⁵ Hospitalist A documented that the patient had end stage liver disease, hepatic encephalopathy, and kidney failure.⁴⁶ Hospitalist A documented that the patient's 90-day mortality risk was 20–30 percent, but the prognosis was not as poor as what the non-VA physicians suggested.

The next day, Hospitalist A documented that “the patient was wide awake and able to answer questions, eating well today, alert and oriented.” The patient, his brother, and Hospitalist A met to discuss the patient's care planning. The patient's brother said the patient had not been alert,

⁴⁵ Ascites is abnormal buildup of fluid in the abdomen that may cause swelling. U.S. National Library of Medicine. PubMed Health. <https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0022961/>. (The website was accessed on June 1, 2017.)

⁴⁶ Hepatic encephalopathy is a buildup of toxins in the brain when a liver cannot remove the toxins from the blood. U.S. National Library of Medicine. PubMed Health. <https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0022965/>. (The website was accessed on June 1, 2017.)

had not eaten for days, and appeared to be terminal at the non-VA facility. A social worker noted after the meeting that the patient's goal was for improvement in health with rehabilitation to increase his strength.

One day later, the patient received blood transfusions for anemia. On the following day, Hospitalist A performed a paracentesis to remove fluid from the patient's abdomen.

A day later, Hospitalist D assumed care of the patient and consulted palliative care. The palliative care physician evaluated the patient and discussed the patient's prognosis of a 1-2-week life expectancy with the patient and his brother. Per the wishes of the patient, the palliative care physician initiated hospice care. The patient died approximately 12 hours later.

Inspection Results

Issue 1: Physicians' Clinical Privileges and Seeking Specialists' Assistance

The OIG did not substantiate that physicians were practicing beyond their clinical privileges and expertise. However, two providers were granted clinical privileges for the System rather than specific to the Facility. OIG staff determined that a surgeon and a hospitalist were granted clinical privileges for procedures that exceeded the Facility's operative and ICU complexity levels, respectively. However, the surgeon and hospitalist had not performed these procedures at the Facility.

Physicians' Clinical Privileging and Credentialing

According to VHA, provider clinical privileges must be practitioner-specific, facility-specific, and within available facility resources.⁴⁷ OIG staff reviewed the clinical privileges granted by the System to the surgeons, hospitalists, and specialists through the credentialing and privileging process.⁴⁸ OIG staff found that two providers were granted clinical privileges for the entire System rather than specific to the Facility as required by VHA.

The Facility and Leavenworth differ in operative complexity: the Facility is designated as standard, and Leavenworth is designated as an intermediate operative complexity. While the OIG determined that a Facility surgeon was privileged to perform procedures, such as a spleen removal surgery, that were not supported by the Facility's standard operative complexity designation, OIG staff reviewed the surgical procedures performed at the Facility and found that the surgeon had not performed these procedures. The Facility must provide personnel support, approved equipment, and the means to handle complications of a procedure. Although surgeons may request clinical privileges at both facilities within the System, the clinical privileges must be unique to the resources available and designations assigned to each facility. Granting surgeons clinical privileges to do specific procedures and matching the resources available within the Facility ensures patient safety.⁴⁹

ICUs are assigned a complexity level with Level 1 defined as the most complex and Level 4 as the least complex. The two ICUs in the System have different designations: the Facility ICU is a Level 4 and the Leavenworth ICU is a Level 3. A Facility hospitalist was granted clinical privileges for the insertion of Swan-Ganz catheters⁵⁰ in an ICU, which required a higher level of

⁴⁷ VHA Handbook 1100.19.

⁴⁸ VHA Handbook 1100.19.

⁴⁹ VHA Directive 2010-018.

⁵⁰ Swan-Ganz catheters are thin tubes inserted into the right side of the heart and arteries leading to the lungs, which are used to monitor the heart's function and blood flow and pressure.

ICU care than the Facility provided. OIG staff confirmed that this procedure had not been performed at the Facility.

Credentialing is a facility's systematic process of screening and evaluating providers' qualifications and other credentials, which includes licensure, education, training, current competence, health status, and experience.⁵¹ OIG staff evaluated Facility providers' expertise by reviewing credentialing folders and found providers had required documentation that included certifications, current licensure, training, education, health status, and experience that supported their specific practices.

Additionally, for the four patients' EHRs reviewed (see Case Summaries, Patients A–D), the OIG did not find that Facility hospitalists and specialty providers practiced beyond their clinical privileges or expertise.

Physicians Seeking Specialists' Assistance

The OIG did not substantiate that physicians failed to seek assistance from specialists, thus patients were not placed at risk. However, OIG staff found that specialty care provider staffing levels⁵² and limited hours of availability resulted in delays, increased lengths of stay, and/or patient transfers. OIG staff found that consults were ordered when medically necessary, and because of the limited hours of specialty coverage, patients were transferred if a specialist was unavailable. Because the transfers were clinically indicated, OIG staff did not review all Facility sentinel events or other adverse events.⁵³

Physicians access specialty provider services by entering EHR consults. VHA requires that an inpatient consult must be designated as stat or routine. If the consult is stat, there must be documented discussion between ordering and receiving providers as to when the patient will be seen. In all other circumstances, the consult should be completed in accordance with the clinically indicated date,⁵⁴ which is defined as "...the date care is deemed clinically appropriate by the VA sending provider."⁵⁵

According to current VHA policy, the Chief of Staff is responsible for "Oversight and facilitation of effective relationships between services using Care Coordination Agreements."⁵⁶

⁵¹ VHA Handbook 1100.19.

⁵² In this report, the OIG uses the term staffing levels, which indicate provider full time employee equivalents assigned to a facility.

⁵³ Sentinel event is a patient safety event that results in death, permanent harm, or severe temporary harm where an intervention is required to sustain life; Adverse events are untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within a facility; Health System Policy Memorandum No.00B-21, *Patient Transfers*, September 3, 2015.

⁵⁴ VHA Directive 1232(1), Appendix B, 2b.(d)(1) and (2).

⁵⁵ VHA Directive 1232(1), 3.d.

⁵⁶ VHA Directive 1232(1), p. 7–8.

One of the required elements in a service/care coordination agreement is the establishment of the timeframe expected for a response from the consultant.⁵⁷

The System's Bylaws and Rules of the Medical Staff provide the following guidance:

The responsibility of determining policy for answering medical consultation requests rests with the clinical SLM [Service Line Manager] and/or clinical supervising physician in the service line sections providing the consultative services. Specific time frames should be identified in service line HSPM [Health System Policy Manual]. Time frames for responding to consultation requests and documenting consultations in the medical record shall be approved by the MEB [Medical Executive Board] and communicated to the Medical Staff. The basic philosophy of the Medical Staff is to provide medical consultation with a high level of professional competency, efficiency, and promptness.

The OIG reviewed patient consults and determined that if consults were placed during the week on evenings or nights, the consult took place the next day. However, critical care patients who received a consult to pulmonology, cardiology, and/or infectious disease on a Friday did not receive consultation until the following Monday. Below are three examples of delayed consults:

1. On a specific Friday in 2016 at 10:10 a.m., a patient had a consult placed to infectious disease with a provisional diagnosis of sepsis due to a right prepatellar effusion in knee post total knee arthroplasty and a chronic diabetic foot infection. The patient was transferred to a non-VA hospital for a higher level of care on the next day at 5:45 a.m.
2. On a specific Friday in 2017 at 12:58 p.m., an ICU patient had a consult placed to pulmonary medicine for assistance in ventilator management. The provisional diagnosis was acute respiratory failure. On Friday, a note in the EHR indicated the hospitalist would request the pulmonologist to see the patient the following Monday to assist as the pulmonary service was out that week. Although the consult was placed on Friday, for this intensive care patient, the clinically indicated date was the following Monday. The provider discussed a transfer to a different facility with the Chief of Staff; however, the family refused the transfer. On Monday, the provider discussed the patient's status with the pulmonologist by telephone. The pulmonologist was not available to see the patient in person. The pulmonologist recommended a consult with palliative care. The patient died Monday afternoon.

A consult was also placed to cardiology on mid-day Friday for assistance in managing cardiac issues with the patient's ventilator. The clinically indicated

⁵⁷ VHA Directive 2008-056, p. A-1; VHA Directive 1232(1), p. A-1.

- date was for the same day. The patient was seen by a cardiologist on Monday morning.
- On a specific Thursday in 2017 at 2:59 p.m., a patient who had been transferred to the ICU had a consult placed to infectious disease for evaluation of a spike in temperature to 105 degrees Fahrenheit, tachycardia, and hypotension. The provisional diagnosis was right upper lobe pneumonia. The clinically indicated date was for that same day; however, the patient was not seen until the next day at 1:46 p.m.

The Facility provided OIG staff with a list of specialists with their full time employee equivalents (FTE) for each of the following specialties.⁵⁸ (See Table 1.)

Table 1. Facility Specialists as of May 15, 2017.

Specialty	Onboard FTEs	Vacancies
Anesthesiologist	1.0	0
Cardiologist	1.0	0
Dermatologist (provides coverage for the Facility and Leavenworth)	0	0
Gastroenterologist	1.25	0
Hematologist/Oncologist	1	0
Infectious Disease/Hepatitis Clinic	1.0	0
Nephrologist	0	0
Neurologist	2.0	0
Ophthalmologist (provides coverage for the Facility and Leavenworth)	2.0	0
Pain Management Specialist	1.0	0
Pathologist	1.0	0
Psychiatrist	8.88	5.0
Pulmonologist	1.0	1.0
Radiologist	2.0	1.0
General Surgery	1.0	1.0
Orthopedic Surgery	0.25	0
Urologist	1.0	0

Source: Facility internal documents as of May 15, 2017.

⁵⁸ FTE is the ratio of the total number of paid hours during a period of time (40-hour work week) by the number of working hours in that period Mondays–Fridays. For example, a position that requires an employee to work 40 out of 40 hours is considered a 1.0 FTE. <http://www.businessdictionary.com/definition/full-time-equivalent-FTE.html>. (The website was accessed on October 5, 2017.)

For most specialties, the Facility had one full time employee who worked during the day. (See Table 2.)

Table 2. Selected Facility Specialist Schedules as of April 2017.

Specialty	Day(s) of Week	Time
Cardiology	Monday–Friday	0800–1630
Gastroenterology	Procedures: Full day-Monday Full day-Wednesday Half day-Friday Clinics: Full day-Tuesday Half day-Thursday	Day Shift only
General Surgery	Monday–Friday	Day Shift only
Infectious Disease	Monday–Friday	Day Shift only
Neurologist	Monday–Friday	Day Shift only
Pulmonology	Monday–Thursday	0800–1630

Source: Facility staff interviews

The OIG found that hospitalists consulted specialists when necessary; however, consults orders written on evenings, nights, or weekends were not addressed until the next day or on the Monday after a weekend consult. Hospitalists stated that there was no harm caused to patients due to this practice; but, sometimes the hospitalists were unaware that a specialist was on leave, and they would not have admitted the patients had they known.⁵⁹ One provider stated that access to specialists was available, but the provider’s concerns were not addressed after 4:30 p.m. or on weekends. In the EHRs OIG staff reviewed, when a specialist was not available, hospitalists offered patients a transfer to another VA or non-VA facility with a higher level of care. Based on interviews and EHR reviews, the OIG found lack of specialty services resulted in delayed patient care and increased lengths of stay. However, OIG staff did not identify patient harm resulting from delayed specialty care in the patients’ EHRs reviewed.

The closest facilities include two local non-VA hospitals, Stormont Vail and St. Francis, and two VA facilities, Leavenworth and Kansas City VA Medical Center. Stormont Vail Hospital is a 586-bed acute care center that provides inpatient, outpatient, and a variety of community outreach services. St. Francis Hospital has 378 beds and was recently acquired through a joint venture between the University of Kansas Health System and a private hospital based in

⁵⁹ Harm is a term used to describe an adverse event which may have caused death or major permanent loss of function, permanent lessening of bodily functions, or increased length of stay or increased level of care.

Nashville, TN. Both community hospitals are within four miles of the Facility; Leavenworth is 64 miles away; and the Kansas City VA Medical Center is 72 miles away.

At the time of the OIG onsite visit, the Facility did not have Memoranda of Understanding (MOU) with the non-VA hospitals or facility service/care coordination agreements between specialists and hospitalists. According to VHA, if a facility has service/care coordination agreements, it “must be established and utilized with a goal of optimizing referral relationships, establishing clear processes, and reducing the need for inspection and rework.” In addition, facilities’ service/care coordination agreements must define which services are covered by the agreement and the expected timeframe for response from the consultant.⁶⁰ Since the onsite visit, OIG staff received an MOU for one non-VA facility that was signed by the System director but not signed by the non-VA facility, and another MOU that was initiated in July 2017. A Cardiology Service Agreement was initiated in July 2017.

The Facility did not have general surgery coverage for evenings, nights, or weekends. Although the general surgeon indicated a willingness to take calls related to surgical patients during non-working hours and would respond to questions when available, other physicians expressed concern about a lack of access to a surgeon at times other than the day shift. VHA policy requires that the Facility has a written plan or policy for the safe and timely transfer of patients who require treatment or therapy the Facility is unable to provide or perform.⁶¹ The System has a policy for transferring patients to and from System facilities and non-VA facilities. Inter-facility transfers are frequently necessary to provide patients with access to specific providers or services.⁶²

The VHA National Director of Surgery told OIG staff it was not acceptable for the Facility to transfer or divert patients as a solution to staffing issues.⁶³

OIG staff reviewed 100 EHRs of patients who were transferred to VA and non-VA facilities and 47 EHRs of inpatients who died at the Facility between April 1, 2016–March 31, 2017. Consults were ordered when medically necessary, and because of the limited hours of specialty coverage, patients were transferred if a specialist was unavailable. OIG staff found the transfers were timely and clinically indicated. The OIG found that the 47 inpatients’ deaths were associated with end-stage diseases.

⁶⁰ VHA Directive 2008-056. This directive was in effect at the time of some of the events discussed in this report; it expired September 30, 2013 and was replaced by VHA Directive 1232(1). The 2008 directive uses the term service agreement and the 2016 directive uses the term care coordination agreement to describe a written agreement between two services that defines their work flow rules, is mutually agreed upon, and signed by the participating service chiefs.

⁶¹ VHA Directive 2010-018.

⁶² Health System Policy Memorandum No.00B-21, *Patient Transfers*, September 3, 2015.

⁶³ Health System Policy Memorandum No.00B-21.

Issue 2: NP's Medical Service Coverage and Supervision

The OIG did not substantiate that an NP was covering the entire inpatient medical service without any help or supervision. OIG staff found that the inpatient medical service had adequate hospitalist coverage. The Facility's NP was practicing within his/her scope of practice⁶⁴ for VA employment and did not require physician supervision.

NP's Service Coverage

In December 2016, a staff physician, who covered the day shift, unexpectedly left the inpatient medical service. This required an NP to work the day shift intermittently without a staff physician physically present on the floor from December 2016 through March 2017. During this time, staff physicians were available to call for backup if the NP needed assistance during the day shift. In early April 2017, a nocturnist transferred to the daytime shift and was paired with the NP to cover the inpatient medical service.⁶⁵

OIG inspectors interviewed Facility staff and reviewed hospitalists' schedules for the 15 months between January 2016 and April 2017. The Facility inpatient medical service employed three physicians, a physician assistant, and an NP to serve as hospitalists. The Facility also used a float physician or a locum tenens provider to cover a physician vacancy every other week for the night shifts.⁶⁶ OIG staff found that hospitalists provided inpatient medical service coverage 24 hours a day, seven days a week.

NP's Supervision⁶⁷

Effective January 13, 2017, VA amended its medical regulations to permit full practice authority for NPs when they were acting within his/her scope of practice for VA employment.⁶⁸ This allowed Advanced Practice Registered Nurses (APRN) to provide primary health care and other related healthcare services to the full extent of their education, training, and certification without

⁶⁴ NPs perform medical care using a scope of practice.

⁶⁵ Although the nocturnist's shift change resulted in a nocturnist vacancy, a physician temporarily covered this position pending a permanent nocturnist replacement.

⁶⁶ A locum tenens physician temporarily fills a vacancy for another physician.

⁶⁷ Senate Bill (SB) 69. Session 2015. State of Kansas.

http://www.kslegislature.org/li_2016/b2015_16/measures/documents/sb69_00_0000.pdf. (The website was accessed on August 10, 2017; Kansas State Board of Nursing, Nurse Practice Act, July 2015 (revised April 2016), <http://www.ksbn.org/npa/npa.pdf>. (The website was accessed on May 1, 2017); Kansas Office of Revisor of Statutes. 65-1130. Advanced practice registered nurse; standards and requirements for licensure; rules and regulations; roles, titles and abbreviations; prescription of drugs authorized; licensure of currently registered individuals. http://www.ksrevisor.org/statutes/chapters/ch65/065_011_0030.html. (The website was accessed on August 10, 2017.)

⁶⁸ VA Advanced Practice Registered Nurse (APRN), Full Practice Authority (FPA), Facility Implementation Briefing. March 2017.

requiring the clinical supervision of physicians.⁶⁹ The March 2017 VHA Advanced Practice Registered Nurse (APRN) Full Practice Authority Implementation Brief stated that medical staff bylaws needed to be amended to recognize APRNs as Licensed Independent Practitioners.

Prior to the VA amendment, APRNs practiced under the regulations of the state where they worked. The Facility's APRNs worked under the requirements of the State of Kansas' Nurse Practice Act. As of April 2016, the state of Kansas Nurse Practice Act Statutes and Administrative regulations stated, "Each APRN shall be authorized to make independent decisions about advanced practice nursing needs of families, patients, and clients and medical decisions based on the authorization for collaborative practice with one or more physicians. This regulation shall not be deemed to require the immediate and physical presence of the physician when care is given by an APRN."⁷⁰

The System's Bylaws and Rules of the Medical Staff, state regulations, and VHA and Facility policies did not prohibit NPs from practicing without a physician physically present as long as NPs were practicing within their scope of practice. The Facility's NP was practicing within the established scope of practice as a hospitalist at the Facility and did not require physician supervision.

The OIG determined that the System's Bylaws and Rules of the Medical Staff had not been modified to be compatible or compliant with 38 CFR 17.415, Full Practice Authority for Advance Practice Registered Nurses.⁷¹ The Joint Commission requires that "medical staff bylaws, rules and regulations, and policies, the governing body bylaws, and the hospital policies are compatible with each other and are compliant with law and regulation."⁷²

Issue 3: Other Issues—Complexity Designation and Specialty Coverage

During the course of the inspection, OIG staff determined that VHA requirements were not met regarding the Facility's operative complexity designations and specialty service coverage.

⁶⁹ Advanced Practice Registered Nurses include NPs, Clinical Nurse Specialists, and Certified Nurse-Midwives.

⁷⁰ Kansas State Board of Nursing, Nurse Practice Act, July 2015 (revised April 2016). <http://www.ksbn.org/npa/npa.pdf>. (The website was accessed on May 1, 2017.)

⁷¹ Legal Information Institute [LII]. Cornell Law School. <https://www.law.cornell.edu/cfr/text/38/17.415>. (The website was accessed on August 10, 2017); VA Advanced Practice Registered Nurse (APRN), Full Practice Authority (FPA), Facility Implementation Briefing. March 2017.

⁷² The Joint Commission Medical Service (MS) 01.01.01.

Operative Complexity Designation

The Facility was designated as a standard operative complexity. The Facility did not meet three VHA requirements.⁷³

1. Surgical Physician Staffing

Inpatient coverage includes a written plan or policy for the availability of a qualified surgeon 24/7 on-call within 60 minutes. Service may be provided by fee or contract at the Facility.

The Facility did not have the availability of a qualified surgeon 24/7 on-call within 60 minutes to meet the inpatient “Surgical Physician Staffing” requirement. OIG staff were told the Facility had one general surgeon, who worked Monday–Friday, from 7:00 a.m. to 4:30 p.m. The Facility’s surgical staffing did not meet VHA requirements.

2. Pre-Operative Risk Assessment

Anesthesia Pre-Operative Assessments are provided by a Certified Registered Nurse Anesthetist (CRNA) or a mid-level provider in-house weekdays day shift and available on-call 24/7 within 15 minutes by phone or 60 minutes in person.

3. Anesthesia Services

Coverage is provided In-house weekdays day shift, on-call 24/7 within 60 minutes.

The Facility did not meet VHA requirements for pre-operative risk assessment or anesthesia services. Anesthesia staff were not available evenings, nights, or weekends to conduct pre-operative assessments or provide anesthesia service coverage. At the time of the OIG onsite visit, the Facility had one anesthesiologist and no CRNAs on staff.

ED

VHA defines an ED as “...a unit in a VA medical facility that has acute care medical and/or surgical inpatient beds and whose primary responsibility is to provide resuscitative therapy and stabilization in life-threatening situations.”⁷⁴

The Facility did not meet the following VHA ED requirements:

The ED/[Urgent Care Center]UCC must be provided with a list of appropriate on-call social work and mental health staff, as well as specialty physicians, including radiologists, who are required to respond to assist the ED/UCC in caring for the patients seen.

⁷³ VHA Directive 2010-018.

⁷⁴ VHA Directive 1101.05(2).

A reasonable expectation for a call back from a consultant who is on call for the ED/UCC is 30 minutes with an expectation under normal circumstances of an onsite evaluation within 60 minutes of the call back.⁷⁵

Facility staff were unable to provide a list of on-call social work and mental health staff, as well as specialty physicians, including radiologists, who were required to respond to assist the ED to care for the patients.⁷⁶ Staff expressed concerns during interviews that they did not know who was on-call or available evenings, nights, and weekends.

The OIG determined that Facility specialty care clinics had only one provider to cover their respective areas during the day shift. The Facility ED and inpatient services did not have a specialty service on-call schedule available after hours for VA or non-VA providers.⁷⁷ Facility managers could not provide OIG staff with a specialty care on-call schedule. Specialty providers were not available in the evenings, nights, and weekends. When patients required an urgent specialty care consult in the ED or as an inpatient during evening, nights, or weekends, they were transferred to another VA or non-VA facility where the requested specialty services were available.

The OIG also found that specialty care providers (consultants) were only available to the ED Monday–Friday during normal business hours. Facility leaders attributed this to an inability to recruit surgeons and physicians to the Facility. However, the Physician Status Report did not indicate unfilled positions for surgeons or specialists. For cardiology, productivity measures and service demand were met with existing staff; therefore, the Facility was not actively recruiting. An interviewee stated that at times, specialty service consultants were on leave for extended periods without arrangements for coverage.

Ultrasound Coverage

VHA requires that all standard radiology examinations, including ultrasound, for emergent and time sensitive exams will be available during all ED hours of operation.⁷⁸ Ultrasound studies may be performed off-site if the Facility has an agreement in place that monitors turnaround times of the ultrasound exams. Studies should be completed and a reading provided within 90 minutes of the order if it is referred to a non-VA facility.

The ED did not meet VHA policy regarding ultrasound services. OIG staff found the Facility did not have ultrasound coverage evenings, nights, weekends, and holidays or an agreement in place with an off-site provider/service to perform the studies. If an emergent or time sensitive

⁷⁵ The Facility only had an ED, not an Urgent Care Center (UCC)

⁷⁶ VHA Directive 1101.05(2).

⁷⁷ The cardiologist was available 7:00 a.m.–4:30 p.m., Monday–Friday; VHA Directive 2010-018.

⁷⁸ VHA Directive 1101.05(2).

ultrasound was needed by an ED patient or an inpatient, the patient was transferred to a non-VA facility.

Conclusion

The OIG did not substantiate that physicians were practicing beyond their clinical privileges and expertise. However, two providers were granted clinical privileges for the System rather than specific to the facility. OIG staff determined that a surgeon and a hospitalist were granted clinical privileges for procedures that exceeded the Facility's operative and ICU complexity levels, respectively. However, the surgeon and hospitalist had not performed these procedures at the Facility. VHA requires that clinical privileges are facility-specific, practitioner-specific, and within available facility resources. Although providers may request privileges at both facilities within the System, the privileges must be unique to the resources available and differing designations assigned to each facility.

The OIG did not substantiate that physicians failed to seek assistance from specialists, thus patients were not placed at risk. OIG staff reviewed the EHRs of the four identified patients and found that they were referred to specialists as needed. However, the OIG found that specialty care provider staffing levels and the limited hours of specialists' availability resulted in delays, increased lengths of stay, and/or patient transfers. At the time of the OIG onsite visit, the Facility did not have MOUs with non-VA hospitals or service/care coordination agreements between Facility specialists and hospitalists. Since the onsite visit, OIG staff received an MOU that was signed by the System director but not the non-VA hospital, and another MOU that was initiated in July 2017. A Cardiology Service Agreement was initiated in July 2017.

The OIG determined that patients were transferred to a higher level of care if the patients' healthcare requirements exceeded a physician's privileges or expertise. To evaluate these transfers, OIG staff reviewed the EHRs of 100 Facility inpatients who were transferred to another VA or non-VA facility and the EHRs of 47 Facility inpatients who died between April 1, 2016, and March 31, 2017. The OIG found that specialty services' consults were ordered when medically necessary; the patients' transfers were timely and clinically indicated; and because of the limited hours of specialty coverage, inpatients were transferred if the specialist was unavailable. OIG staff also found that the 47 inpatients' deaths were associated with terminal end-stage disease.

The OIG did not substantiate that an NP was covering the entire inpatient medical service without any help or supervision. OIG staff found that hospitalists provided inpatient medical service coverage 24 hours a day, 7 days a week. The OIG also found that the NP was acting within his/her scope of practice for VA employment and did not require physician supervision.

In March 2017, VHA determined that Facilities' medical staff bylaws needed to be amended to recognize APRNs as Licensed Independent Practitioners. OIG staff reviewed the System's Bylaws and Rules of the Medical Staff and found it had not been modified to be compatible or

compliant with 38 CFR 17.415, Full Practice Authority for Advanced Practice Registered Nurses.

During the inspection, OIG staff found that the Facility was not meeting VHA requirements related to surgical complexity designations and ED specialty service coverage. The Facility was designated as a standard operative complexity but did not comply with after-hours requirements for surgeon staffing, pre-operative risk and anesthesia assessments, or anesthesia service coverage. Staff stated that patients awaiting admission or inpatients that required surgery after-hours were either diverted or transferred to a non-VA facility.

The OIG determined that specialty care clinics had only one provider to cover their respective areas during the day shift. The Facility ED and inpatient services did not have a specialty service on-call schedule available after hours for VA or non-VA providers. VHA requires that an ED must be provided with a list of on-call social workers, mental health staff, specialty physicians, and radiologists; who are required to respond to assist the ED in caring for patients.

When patients required an urgent specialty care consult in the ED or as an inpatient during evenings, nights, or weekends, patients were transferred to another VA or non-VA facility where these specialty services were available. According to VHA Directive 1101.05(2), an ED provider can reasonably expect a call back from a consultant who is on-call for the ED/UCC within 30 minutes and, under normal circumstances, an onsite evaluation within 60 minutes.

The OIG also found that the Facility did not have ultrasound coverage on evenings, nights, weekends, and holidays. VHA requires that radiology examinations, including ultrasound, be available during all ED hours of operation.

The OIG made six recommendations.

Recommendations 1–6

1. The System Director ensures provider privileges are facility-specific as required by Veterans Health Administration Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
2. The System Director ensures the System's Bylaws and Rules of the Medical Staff are updated to reflect compatibility and compliance with 38 CFR 17.415, Full Practice Authority for Advance Practice Registered Nurses.
3. The System Director ensures the Facility meets the requirements for physician staffing for inpatient coverage, pre-operative risk and anesthesia assessments, and anesthesia services in-house coverage as required by Veterans Health Administration Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.
4. The System Director reviews the timeliness of specialty care consults and ensures that specialty consults are provided timely as required by Veterans Health Administration policy, including the use of service/care coordination agreements as necessary to define time frames.
5. The System Director ensures the Facility provides a list to the Emergency Department and inpatient staff of appropriate on-call social work and mental health staff, as well as specialty physicians, including radiologists, as required by Veterans Health Administration Directive 1101.05 (2), *Emergency Department*, September 2, 2016, (amended March 7, 2017).
6. The System Director ensures the Facility provides and monitors the availability and timely response of specialty consultants and ultrasound services in the Emergency Department as required by Veterans Health Administration Directive 1101.05 (2), *Emergency Department*, September 2, 2016, (amended March 7, 2017).

Appendix A: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: April 4, 2018

From: Director, VA Heartland Network (10N15)

Subj: Healthcare Inspection—Alleged Mismanagement of Care at the Colmery-O'Neil VA Medical Center within the VA Eastern Kansas Health Care System, Topeka, Kansas

To: Director, Office of Healthcare Inspections (54DV)
Director, Management Review Service (VHA 10E1D MRS Action)

1. Please find the initial status response for the Healthcare Inspection—Alleged Mismanagement of Care at the Colmery-O'Neil VA Medical Center within the VA Eastern Kansas Health Care System, Topeka, Kansas.
2. I have reviewed and concur with the facility's response.
3. Thank you for this opportunity to focus on continuous performance improvement.
4. For additional questions, please feel free to contact Mary O'Shea, VISN 15 Quality Management Officer at 816-701-3000.

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William P. Patterson, MD, MSS
Network Director
VA Heartland Network (VISN 15)

Appendix B: System Director Comments

Department of Veterans Affairs Memorandum

Date: April 4, 2018.

From: Director, VA Eastern Kansas Health Care System –Colmery-O'Neil VA Medical Center (589A5/00)

Subj: Healthcare Inspection—Alleged Mismanagement of Inpatient Care at the Colmery-O'Neil VA Medical Center within the VA Eastern Kansas Health Care System, Topeka, Kansas

To: Director, VA Heartland Network (10N15)

1. Thank you for the opportunity to respond to the recommendations in the draft report *Healthcare Inspection—Alleged Mismanagement of Care at the Colmery-O'Neil VA Medical Center within the VA Eastern Kansas Health Care System, Topeka, Kansas*
2. I have reviewed the draft report and concur with the recommendations.
3. Corrective action plans have been established with planned completion dates as outlined in the attached report. If additional information is needed please contact my office at 913-682-2000.

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Paula Roychaudhuri, FACHE
Associate Director, VA Eastern Kansas Health Care System

Comments to OIG's Report

Recommendation 1

The System Director ensures provider privileges are facility-specific as required by Veterans Health Administration Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

Concur.

Target date for completion: August 2, 2018

Director Comments

The facility Chief of Staff and Credentialing Supervisor will review all current privileges and modify privileging forms as needed to reflect the use of facility-specific privileges.

Recommendation 2

The System Director ensures the System's Bylaws and Rules of the Medical Staff are updated to reflect compatibility and compliance with 38 CFR 17.415, Full Practice Authority for Advance Practice Registered Nurses.

Concur.

Target date for completion: Completed

Director Comments

The Facility bylaws and Rules of the Medical Staff were modified on July 31, 2017, to reflect compatibility and compliance with Code General Register 38 Section 17.415, Full Practice Authority for Advanced Practice Registered Nurses.

OIG Comment

The System provided sufficient supporting documentation, and the OIG considers this recommendation closed.

Recommendation 3

The System Director ensures the Facility meets the requirements for physician staffing for inpatient coverage, pre-operative risk and anesthesia assessments, and anesthesia services in-house coverage as required by Veterans Health Administration Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.

Concur.

Target date for completion: July 1, 2018

Director Comments

The facility is currently working with VISN 15 leadership to propose a reduction in the surgical complexity levels at both facilities. The Dwight D. Eisenhower is proposed to be standard complexity. The Colmery O'Neil VAMC is proposed to be ambulatory basic complexity level. Concurrently, the facility is in the process of recruiting additional surgical staff to meet VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform, Standard, Intermediate, or Complex Surgical Procedures*.

The Dwight D. Eisenhower VA Medical Center (Leavenworth) currently maintains an Anesthesia Call schedule. Colmery O'Neil VAMC currently does not maintain an anesthesia call schedule due to limited surgical case activity after business hours. In fiscal year 2017, 96 percent of cases met ambulatory basic criteria and were performed during business hours.

Recommendation 4

The System Director reviews the timeliness of specialty care consults and ensures that specialty consults are provided timely as required by Veterans Health Administration policy, including the use of service/care coordination agreements as necessary to define time frames.

Concur.

Target date for completion: July 1, 2018

Director Comments

A Facility Consult Management Health System Policy Memorandum is in place. Compliance with timeframes are reviewed in the daily access huddles that are held by the facility Group Practice Manager. Consult outliers and stat consults are reported in the Director's morning report daily.

Timeliness of Community Care referrals are reviewed by the Community Care Oversight Council during regularly scheduled meetings, with the goal of care received within thirty days of the Patient Indicated Date, regardless of whether the authorization is created using Community Care, Choice, Sharing Agreement, or other community authorization programs.

The Facility Chief of Staff, Deputy Chiefs of Staff, and Medicine Service Chiefs will review internal service agreements and develop or revise service agreements for specialty services as necessary.

Recommendation 5

The System Director ensures the Facility provides a list to the Emergency Department and inpatient staff of appropriate on-call social work and mental health staff, as well as specialty

physicians, including radiologists, as required by Veterans Health Administration Directive 1101.05 (2), *Emergency Department*, September 2, 2016, (amended March 7, 2017).

Concur.

Target date for completion: May 30, 2018

Director Comments

On-call lists that outline behavioral health, social work, and on-call specialty services are posted on the facility SharePoint and are accessible by all staff. The Administrator of the Day on each facility campus also has access to the on-call lists. On call radiological services are provided by the National Teleradiology Program after business hours. Staff were provided education on the location of the facility on-call lists. On-call lists will be reviewed to ensure all appropriate specialty services' on-call status is posted.

Recommendation 6

The System Director ensures the Facility provides and monitors the availability and timely response of specialty consultants and ultrasound services in the Emergency Department as required by Veterans Health Administration Directive 1101.05 (2), *Emergency Department*, September 2, 2016, (amended March 7, 2017).

Concur.

Target date for completion: July 31, 2018

Director Comments

Memorandums of Understanding (MOU) with community facilities were modified to include timeframes for ultrasound study completion and reading in accordance with VHA Directive 1101.04(2), *Emergency Department*. The facility Chief of Staff will work with the Business Development office to develop MOUs with community partners for specialty consultants as needed.

Staff Acknowledgments

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