



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection Review of Quality of Care at a VA Medical Center

To Report Suspected Wrongdoing in VA Programs and Operations:

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Executive Summary

In response to a congressional request, the VA Office of Inspector General, Office of Healthcare Inspections conducted an inspection to assess the quality of a veteran's care at a VA Medical Center (the medical center) and to determine if the events leading to the veteran's death were connected to any issues with the quality of care.

Our review identified three areas that the medical center could improve on. Specifically, the medical center needs to ensure smooth transitions when there are changes in veterans' providers and/or care settings. The medical center also needs to improve internal communications between providers and external communications with veterans and other parts of the VA system to ensure that significant information is communicated timely and with individuals who have a need to know. Lastly, the medical center needs to review the procedures of the Disruptive Behavior Committee to ensure clear and consistent messages about patient risk and to promote patient-centered solutions when risks are identified. Whether addressing these three issues previously would have resulted in a different outcome for the veteran is unknown.

We also reviewed prescription medication delivery because the veteran had frequently complained that his medications were not delivered on time. Although we identified a few instances where there were delays in filling or delivering medications for this veteran, we did not identify a consistent pattern of delays.

We recommended that medical center leadership: (1) review, and revise as needed, its policies and procedures for providing case management for veterans who have complex medical and psychosocial issues; (2) review its policies and practices to ensure effective communication with veterans when there are changes in their providers or care settings; (3) work with Veterans Health Administration (VHA) leaders to identify ways, within existing privacy laws, to improve sharing between VHA and the Veterans Benefits Administration of information about unusual events impacting services; and, (4) review the policies and practices of the Disruptive Behavior Committee and implement procedures to ensure that risks are communicated timely and consistently and conveyed with a patient-centered focus.

The Veterans Integrated Service Network and Medical Center Directors concurred with the findings and recommendations and provided acceptable actions plans. We will follow up on the planned actions until they are completed.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director

SUBJECT: Healthcare Inspection – Review of Quality of Care at a VA Medical Center

Purpose

VA's Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) conducted an inspection to assess the quality of a veteran's care at a VA Medical Center (medical center) and to determine if the events leading to the veteran's death were connected to any issues with the quality of care.

Background

A member of Congress requested the OIG to review the care of a deceased veteran. The letter requested a review of the "level and type of care" provided to the veteran and to evaluate whether the veteran's death was "connected to any issues with the quality" of the veteran's medical care.

Scope and Methodology

We conducted site visits to the main facility and a community based outpatient clinic (CBOC) September 27–29, 2010. We reviewed the veteran's medical records and disability compensation claims folder, protected peer review documentation, applicable medical center and Veterans Health Administration (VHA) policies, and other relevant documentation. We also interviewed medical center and regional office leaders, the Chief of Staff, the chair of the Disruptive Behavior Committee (DBC), the Primary Care Service Line manager, and clinical staff at the medical center and CBOC.

We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Case Summary

The following chronology is from the veteran's VA medical records, which included some notes from a care provider other than VA. The chronology also includes pertinent information obtained from prior congressional inquiries made on behalf of the veteran in

2006, letters the veteran sent to the medical center, and correspondence contained in the veteran's disability compensation claims folder.

Medical Care and Treatment. The veteran first came to the medical center in December 2005 following cancer treatment for a rare and aggressive form of cancer. The veteran was diagnosed with cancer years earlier, while still on active duty. Aggressive treatment of the disease prior to the time the veteran presented for VA care resulted in serious complications. An outside care provider also treated the veteran for other physical disorders that contributed to his chronic pain. The outside care provider also treated the veteran for major depressive disorder, and the veteran continued follow-up care through the outside care provider while he was a patient at the medical center.

When he presented to the VA CBOC in December 2005, the veteran requested to become an established primary care patient and obtain his prescription medications. He was assigned to a primary care provider (PCP) and first seen that month. His second clinic visit in early January 2006 was canceled by clinic staff, but the veteran did not receive notification. The veteran was next seen by his PCP in mid-February and was referred to mental health for ongoing depression. The veteran called the mental health clinic in early March for an appointment and was scheduled for a mid-April appointment, which he later cancelled.

In mid-May 2006, the veteran contacted a member of Congress, expressing his dissatisfaction with the timeliness of obtaining prescription medication refills at the medical center, the assignment of a physicians' assistant as his PCP, and the "low caliber" of VA medical employees. In addition, the veteran directly faxed letters to a CBOC in mid-June, complaining about delays in receiving prescription medications and difficulties in communication with the CBOC staff. In his letters, the veteran requested that all communication be in written form by email or fax because he was often away from home. In late June, leadership at the medical center also received a letter from a member of Congress about the veteran's concerns. Following these letters, the medical center assigned the veteran to a new PCP and made him a new appointment with a mental health provider at the main facility.

In late June 2006, the veteran was first seen by oncology at the main facility. The clinic note stated that the outside care provider would retain primary management of the veteran's cancer treatment. The medical center would monitor his condition and prescribe his local medications, which at the time included some Drug Enforcement Administration (DEA) Schedule II drugs. The veteran continued to be followed in the oncology clinic until September 2008. The notes did not explain why the veteran stopped being followed at that time.

In early August 2006, the veteran was seen by a psychiatrist in mental health and was diagnosed with ongoing depression *without* suicidal or homicidal ideation. In late August, he made two phone calls to the mental health clinic reporting that his mental

health medication was not working. He did not attend his early September mental health clinic appointment. The medical record documents that a “no show” letter was sent to the veteran. The veteran was not seen again in mental health until December 2006. Because this was an urgent appointment, he was seen by a different provider.

In March 2007, the veteran’s PCP reported that the veteran had been a “no show” for three successive appointments, and, after several attempts to contact the veteran via mail, the veteran was removed from the PCP’s patient panel. In late June, the CBOC sent the veteran a letter stating that he would no longer be followed by the PCP and that his conditions, including prescription medications, would be “treated by oncology.”

The veteran continued to be followed at the main campus in oncology, mental health, and orthopedics. In July 2007, he underwent successful orthopedic surgery. Following the surgery, his psychiatrist noted improvement in his depression, as well as his physical condition.

In February 2008, the veteran requested to be assigned to a PCP at another CBOC, which was closer to his home. He was seen by his new PCP in February; however, he missed his next clinic appointment at the CBOC in early March 2008. CBOC staff sent the veteran a letter requesting he call them concerning the missed appointment. There is no evidence in the record that the veteran returned the call.

According to the medical record, when a social worker contacted the veteran in late March 2008 to see if he was interested in more extensive mental health services, not just medication management, he reportedly refused to schedule an appointment, stating that he was “sick of it” and that he would not be coming to the VA anymore. In early August 2008, the veteran was seen by a mental health nurse practitioner for medication management at the CBOC. At that time, the provider noted increased depression symptoms. The veteran missed his mental health clinic visits in late August and mid-September. The medical record states that a letter was sent to the veteran requesting he reschedule his appointments.

The veteran was not seen again by his CBOC mental health provider until late October, at which time the provider documented that the veteran’s symptoms continued to worsen and that admission might be needed if there was no improvement with a change in medication. In the medical record, the provider documented his concerns for the veteran’s personal safety and welfare due to physical maladies and other dire circumstances. He considered the veteran a high risk for suicide due to, among other circumstances, cancer, a shortened military career and isolation. The provider requested to see the veteran again in 1 month.

After the veteran’s October 2008 mental health appointment, his mental health provider left the medical center, and the veteran was reassigned to a mental health physician assistant, who was located at still another CBOC. The veteran was seen by the CBOC

provider via telehealth in mid-December. The provider noted that the veteran was “increasingly depressed”; although the veteran denied “suicidal ideation.” The provider requested to see the veteran (via telehealth) in 3–4 weeks.

The veteran continued to be seen by the CBOC mental health provider via telehealth from January through May 2009, and the provider’s notes reported “no change in depression.” The notes, however, documented increased symptoms, such as inability to sleep, decreased eye contact, and tearfulness. During this period, the provider consulted with the veteran’s outside care provider, who recommended increasing the veteran’s medications. It is not clear from the medical records whether the provider also consulted with a VA psychiatrist. The veteran’s last CBOC mental health clinic visit was in late May 2009. According to the medical records, the veteran was to call his provider to schedule an appointment when he returned to the area, but he did not.

In early June 2009, the veteran called the medical center and expressed anger about delays in receiving his prescription medications. He missed a PCP appointment in early June but was seen later in the month. The June 2009 PCP appointment was the last *completed* primary care appointment documented in the veteran’s record. However, the record documented multiple telephone contacts from the veteran between September and December 2009, requesting his pain and psychiatric medications.

In early December 2009, the veteran called the second CBOC he visited to complain about delays in receiving his prescription medications. During the call, the veteran reportedly made threatening comments. CBOC staff reported the threats to VA Police, who notified local law enforcement. According to the medical records, the pharmacy filled the prescriptions 2 days after the veteran’s request and sent them to him via express mail. However, the first attempt to deliver the medications was not successful because the veteran was reportedly not at home to accept them. The medications were delivered on the same day the veteran made threatening comments.

The CBOC staff also reported the threatening comments to the medical center’s DBC. The DBC discussed the case in late January 2010 and recommended sending a letter to the veteran about his behavior. However, the veteran’s mental health provider expressed concern that a letter from the DBC without direct discussion with the veteran might exacerbate the situation. Therefore, the DBC agreed to give the provider time to talk to the veteran, but the provider was reportedly unable to reach him by phone after several attempts.

In early February 2010, the medical center assigned the veteran a new PCP at the main facility and sent the veteran a letter notifying him of his new PCP and a scheduled appointment with the PCP in late February. (This was a separate letter from the one recommended by the DBC.) After receiving the letter, the veteran called the second CBOC and reportedly stated that he did not want to change providers. The veteran did not attend his February PCP appointment at the main facility.

In March 2010, the DBC sent a letter to the veteran advising him that his health care would only be delivered at the main facility. The letter also stated that his medications would be renewed for 30 days only and that if he missed his appointments, his medications would be discontinued.

The veteran's last pain medication prescription (for a 30 day supply) was recorded in late February 2010, and his last non-opioid¹ medication refill was in early March 2010. In late April, the veteran presented at the second CBOC with letters he had received from the DBC and VBA. CBOC staff referred him to the main facility. As a result of this visit, the DBC sent a second letter to the veteran in May explicitly stating that he was not permitted at the second CBOC and would be subject to arrest if he violated the order. The letter was returned to the DBC as undelivered.

In early May, the veteran was seen by his newly assigned PCP at the main facility. According to the provider's notes, the veteran became "upset" when he found out that the provider was "not fully aware of his past medication history." He left before the visit was completed. The PCP followed up by sending the veteran a letter thanking him for making the trip to the main facility, requesting his help with his medications, and notifying him that his former oncologist was willing to continue his care. Based on the medical records, the early May visit was the last time the veteran was seen at a VA clinic prior to his death.

Disability Rating and Compensation. During the period the veteran was an outpatient at the medical center, he was also seeking compensation from VBA for numerous conditions. VBA granted service connection for three conditions at 0 percent and 10 percent entitlement for multiple non-compensable service-connected disabilities.

In August 2006, the veteran missed a third scheduled C&P medical examination. However, in October 2006, based on information obtained from the veteran's private medical records, VBA increased the evaluation for the cancer from 0 percent to 100 percent and granted service connection for major depressive disorder at 50 percent. VBA deferred increased evaluations for other conditions pending further medical evidence.

In August 2008, the veteran attended a C&P medical examination for the cancer, and VBA continued the 100 percent evaluation. In October 2009, VBA requested another C&P examination for the veteran's cancer, but the veteran requested that the examination be deferred due to his compromised immune system. The examination was scheduled for February 2010. In November 2009, VBA also requested that the veteran complete a release of information to obtain his health care records from the other provider and a

¹ Opioid medications are frequently used to relieve both acute and chronic pain but have a high potential for abuse. Common opioids include morphine, fentanyl, and oxycodone.

private cancer treatment facility. According to VBA records, the veteran did not respond to the request.

In February 2010, the medical center notified VBA that the veteran did not attend his scheduled C&P medical examination. In mid-March, VBA proposed to reduce the veteran's cancer evaluation to 0 percent because he had not reported for the C&P medical examination and medical evidence did not support that the cancer was active. VBA sent the veteran a letter which stated:

“The medical facility scheduled your examination for February 11, 2010, but you did not report. Without the exam findings, we do not know how disabling the condition is now. The law requires that veterans report for examination when requested to do so. If a veteran misses the exam without a good reason, we must stop or reduce payments depending on what the medical evidence on file shows. Because you did not report for the exam, we propose to adjust the individual evaluation for each service-connected condition as shown in the table below. Your monthly rate of compensation will change from \$2,673.00 to \$770.00 effective May 15, 2010.”

In March, based on the medical center records indicating a “possible worsening” of the veteran's major depressive disorder, VBA requested a C&P mental health examination. However, in April 2010, the medical center notified VBA that the veteran did not attend his scheduled C&P mental health examination. As a result, VBA did not increase the veteran's service connection for major depressive disorder.

In mid-May 2010, the due process period for the proposed reduction of benefits for the cancer expired, and a new rating decision was prepared. In late June 2010, VBA sent a letter to the veteran notifying him of the reduction in his benefits. An excerpt from the letter stated:

“What Happens Now – Because you did not report for a required examination, the law says we must change the evaluation of your service-connected disability that is subject to improvement. Here is the condition and its evaluation.

Your [cancer] which was 100% is now considered 0% disabling.”

The letter also advised the veteran that he could contact VBA and let them know he was “ready to report for an examination,” and it provided information on appealing VBA decisions. The veteran reportedly did not contact VBA after receiving this letter.

Inspection Results

Because the veteran continued to be treated by an outside care provider, his main needs from the VA were primary care, prescription medication delivery, laboratory and other

ancillary services, mental health medication management, periodic oncology follow-up, and orthopedic surgery.

Based on our record reviews and interviews, we identified three issues pertaining to coordination of care, communication, and the DBC that require medical center leadership attention. We also reviewed prescription medication delivery because the veteran had frequently complained that his medications were not delivered on time. Although we identified a few instances where there were delays in filling or delivering medications for this veteran, we did not identify a consistent pattern of delays.

Coordination of Care. To provide comprehensive, high quality patient care to veterans with different needs and levels of complexity, VA medical facilities must coordinate care and services. Coordination of care and services also ensures continuity, prevents duplication, and positions facilities to better meet patients' ongoing and changing health care needs.

Continuity of Care. We found that the veteran's care often appeared to be fragmented. The veteran was assigned to four PCPs and mental health providers in 4 years. Some of the provider changes were unavoidable because providers left the medical center or the veteran voluntarily changed care locations. When changes did occur, the medical records did not show that there was a clear "hand-off," indicating that the providers discussed the transitions with the veteran or that the pertinent facts about the veteran's condition and care were communicated between providers. This would have enhanced opportunities to improve care coordination. The new providers relied in part on the medical records, which, for this patient, often lacked detail.

We also found gaps in care and times when the veteran appeared to be lost to follow-up. For example, in September 2008, the veteran stopped being followed by oncology; yet, his medical records did not explain why (or if) oncology follow-up was no longer necessary. There were multiple contributing factors to these gaps in the veteran's care, some of which were outside the control of medical center staff. The veteran frequently missed his scheduled clinic and C&P appointments without notice or explanation. In some cases, his appointments with the outside care provider made it hard for him to be available for scheduled VA appointments, and, on at least one occasion, the veteran expressed concern about being exposed to the flu during his clinic visits because of a suppressed immune system. While the VA clinics would call or send "no show" letters immediately after a missed appointment, there was no evidence of follow through by clinic staff at later dates. One provider pointed out that if a patient refuses care, misses appointments, and does not respond to "no show" letters, facility staff cannot "force care" on the veteran. Two other providers told us that the veteran was most compliant when he was allowed to come in whenever he was home instead of making fixed appointments. For example, the veteran made and kept frequent appointments with the oncology clinic between June 2006 and June 2008.

Case Management. The veteran had very complex medical conditions that, coupled with his depression and pain medications, elevated his risk for complications and for noncompliance with care. In our interviews, clinicians and managers at the medical center agreed that case management might have reduced some of these problems. Case management provides a formal process for planning, managing, and communicating a patient's health care needs in an interdisciplinary setting. We found that the medical center had several established case management programs, as required by VHA. For example, case management is provided for veterans with severe mental illness and certain Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans.

Despite the complexity of the veteran's condition, the veteran was not assigned a case manager and was not offered case management until December 2009, after the veteran made threatening comments against the facility. Three days after the veteran made the threatening comments, an OEF/OIF case manager contacted him, but the veteran reportedly told the case manager that he had "no use for the VA." According to medical center staff we interviewed, the veteran was not initially considered for case management because he did not meet the criteria for the established case management programs. One medical center official described this situation as case management "in silos"—that is, case management is specific to a diagnosis or diagnoses, not necessarily to the complexity of medical and psychosocial needs. This official also stated that medical center leadership has initiated a review of all mental health patients with Patient Record Flags² to determine how coordination of care may be improved at the medical center.

Communication. Coordinated care requires regular communication between the patient and caregivers and other individuals involved in care delivery. Based on our review of the veteran's medical records and interviews with his care providers, we found that communication could have been better throughout the veteran's care at the medical center, especially as individual caregivers became aware that the veteran was gradually declining, appearing more disheveled, and often cursing on telephone calls with staff.

Medical Center and Veteran. Within 6 months of initiating his care at the medical center, the veteran raised concerns about communications with medical center staff and that he often did not get messages about appointment dates until it was too late to attend appointments. In late June 2006, the veteran requested that medical center staff not communicate with him by phone, but instead by email or fax. With email, he would have access to messages when he was away from home, which was often the case due to frequent trips for medical care. We found no evidence that medical center staff honored the veteran's request for email or fax communication between June 2006 and October 2008 a period during which the veteran was temporarily displaced. Medical center staff

² A Patient Record Flag, informally referred to as a "flag," is an alert that is placed in a patient's electronic medical record to make providers aware of potential risk factors. VA facilities must follow strict procedures for placing "flags" in patient records to ensure their appropriate use.

continued to use the phone or U.S. mail as its main form of communication with the veteran.

During the veteran's temporary displacement, it is not known if the veteran had email or fax capabilities in his temporary housing. According to staff members at a CBOC, the veteran used a cell phone and often had problems with poor cell phone coverage and dropped calls. One staff member stated that the veteran often had to leave his home and drive to a location with better reception to complete his calls to the clinic. According to the veteran's medical records, medical center staff frequently left messages on the veteran's phone without getting replies. We could not determine if the veteran's non-responsiveness to these calls was due to his frequent travel to another care provider, poor cell phone reception, or an unwillingness to respond.

During our interviews with medical center staff, they described the veteran as a likeable, polite, young man who was articulate and knowledgeable about his conditions. However, his behavior reportedly started to change in 2009, and medical center staff told us that *prior* to the veteran's threatening comments in December 2009, there had been a few occasions where the veteran became "verbally aggressive," using profanity on the telephone. We found little or no documentation of these episodes in the veteran's medical record. In addition, we found no documentation that the veteran's health care providers had discussed these episodes with the veteran or between themselves to determine if further intervention was warranted. When the DBC decided to send the veteran a letter after the December 2009 incident, there were no direct discussions with the veteran as to what the letter meant and why the change from the CBOC to the main facility was necessary. The provider documented trying to contact the patient by phone on 3 separate days but was unable to make contact.

Medical Center and VBA. In late June 2010, VBA sent the veteran a letter to notify him that his disability compensation was being reduced because he failed to show for required C&P medical examinations. The letter was sent less than 3 months after the medical center's DBC sent the veteran a letter informing him that he now had to receive his care at the main facility. According to the VBA Regional Office Director, he was not aware that the medical center had concerns about the veteran's behavior or that they had sent the veteran a letter essentially barring him from the CBOC. He added that had he known, he would have tried to make direct contact with the veteran before sending the notification letter.

Furthermore, the medical center Director stated that he was not aware that VBA had sent the letter to the veteran concerning a reduction in benefits. Both the medical center and Regional Office Directors told us that there needs to be a better mechanism by which the medical center and VBA can share information about significant events related to the veterans they are serving.

Disruptive Behavior Committee. The DBC was established to promote a safe working environment by identifying patients with high risk for threatening, assaultive, or disruptive behavior and working with staff to prevent or manage the behavior. We found that the DBC could have been more consistent in its message as to the seriousness of the December 2009 incident, communicated to the veteran in a more patient-centered way, and documented its decisions better.

Consistent Message. Although the veteran made threats against the medical center in early December 2009, the DBC did not meet to discuss the issue until its regularly scheduled meeting in late January 2010, almost 7 weeks later. During this meeting, the DBC reportedly decided that the veteran could no longer go to the CBOC due to safety concerns for the CBOC staff and that the veteran would have to receive his care at the main facility. However, according to the letter the DBC sent the veteran, they did not feel that his behavior warranted placement of a flag in his medical record. In addition, the DBC did not send the letter to the veteran until late March, over 3 months after the incident at the CBOC.

Moving the veteran's care from a CBOC, which was located close to the veteran's home, to the main facility, which was located more than 100 miles away, conveyed a strong message that the DBC felt clinical staff were at risk. Yet, the delays in meeting and sending the letter to the veteran, as well as not placing a flag in the veteran's medical record, suggested otherwise.

Patient-Centered Communication. Providing patient-centered care to veterans who exhibit threatening or disruptive behavior is difficult. Communicating concerns and decisions with these veterans can be even more difficult and, if done improperly, can exacerbate situations. The letter that the DBC sent the veteran in March 2010 (and which was signed by the medical center director) included verbiage that could have been more patient-centered. For example, the letter referred to the decision not to place a flag in the veteran's medical record. While the term "flag" is commonly used and understood by clinical staff in the VA, some patients may interpret the use of flag as punitive. In addition, while we recognize the necessity of adherence to policy for close clinical follow-up and monitoring for patients who are dispensed narcotic pain medications, one might construe the letter's specific wording as ill-advised given the history of prior concerns regarding medication expressed by this particular patient.

Documentation of Decisions. We reviewed the January DBC meeting minutes and found that the discussion leading to the decision that the veteran's care should be moved from the CBOC to the main facility was not documented. Specifically, the minutes did not include any discussion as to whether the DBC considered other alternatives that may have been less disruptive to the veteran, such as offering the veteran fee-basis care or offering transportation assistance to the main facility.

Prescription Medication Delivery. Beginning in March 2006, the veteran routinely reported difficulties in getting his prescribed medications on time. The main difficulties seemed to be with the veteran's pain and psychiatric medications. Most of his pain medications, as well as one of his psychiatric drugs, were Schedule II drugs, which are controlled substances with a high risk for abuse. VHA Handbook 1108.1, *Controlled Substances (Pharmacy Stock)*, dated October 4, 2004, requires that prescriptions be ordered on VA Form 10-2577 and generally not exceed 30 day supplies. Refills are prohibited for Schedule II drugs which mean that a new prescription must be written each time the supply runs out. The Handbook outlines strict criteria that must be met for a veteran to receive multi-month prescriptions of Schedule II drugs.

We found a few instances where the medical center did delay filling and/or delivering the veteran's medications; although, we did not find a pattern of delays for this veteran. Up until March 2006, the outside care provider supplied the veteran with most of his medications, including his pain medications. In late March 2006, the veteran requested narcotic pain medications at a CBOC; however, because his PCP was not in, the CBOC staff told the veteran that no other provider would write a narcotic prescription for him. A few days later, the PCP spoke with the veteran and explained the requirements for obtaining controlled substances.

The veteran seemed to struggle with the requirements for filling prescriptions for narcotics and complained to his congressional representatives. He also wrote a letter to the medical center director in late June 2006, complaining of VA's delays in filling his prescriptions. The veteran stated:

“When I am able to get to the VA to respond to my requests for medication refills, it takes on average of three weeks. Considering the VA only provides 30 day supplies at a time for these particular medications you would think I would not have to submit a request for refill; a permanent refill request would make sense. It has gotten to the point that I routinely take half doses of medications, because I know despite submitting refill requests in a timely manner I will always run out before the VA takes any action at all on the refills.”

In response to the veteran's concerns, a medical center clinical pharmacist contacted the veteran in late June, but the veteran declined to speak with the pharmacist, stating that he had already discussed the issue with someone else at the medical center. The veteran's medical records did not document any further complaints until December 2008, when there was a 9-day delay in sending the veteran his medications, resulting in the veteran reportedly being out of pain medication for several days.

Several staff members told us that the veteran often waited until he was out of medication before ordering more, or he would call in his requests on Fridays, when the outpatient pharmacy was not able to fill the prescriptions until Mondays. On several occasions he

also reported that he was completely out of medications. When the veteran did request prescriptions by phone or walk-in, medical center staff generally documented it in his medical records. Our review of the documented requests found that they occurred at irregular intervals, ranging from 13 to 43 days, which suggests an inconsistent pattern of medication usage. We also found that the veteran's PCP at the CBOC often ordered additional pain and psychiatric medications through a local pharmacy when the veteran ran out, in an effort to accommodate the veteran and ensure he did not go without his medications.

Conclusions

The veteran came into the VA system with a complex mix of interdisciplinary medical and mental health problems, chronic pain, and psychosocial issues. By all accounts, he enjoyed a successful military career until it was cut short by a devastating disease and serious complications resulting from the treatment of that disease. The veteran's experience with the VA system had a difficult start, followed by alternating periods of smooth and difficult interactions. There were times, especially early on in his treatment, that the veteran was fully engaged and proactive in communicating his health care needs. There were other times when he disengaged from his health care providers, declined needed services, and missed scheduled appointments. Unfortunately, there is no way to know if the veteran's disengagement was the result of his frustration with the VA system, a consequence of his disease process, a response to other challenges in his life, his way of coping with a terminal disease, or a combination of all these factors.

Our review concluded that there are three areas that the medical center could improve on. Specifically, the medical center needs to strengthen care coordination to ensure continuity of care and smooth transitions when there are changes in providers and/or care settings. Implementing case management approaches that take into account interdisciplinary complexity, versus just being diagnosis-driven, would be beneficial. The medical center also needs to improve internal communications between providers and external communications with veterans and other parts of the VA system to ensure that significant information is communicated timely and with individuals who have a need to know. Lastly, the medical center needs to review the procedures of the Disruptive Behavior Committee to find ways to ensure clear and consistent messages about patient risk and to promote patient-centered solutions when risks are identified. Whether addressing these three issues previously would have resulted in a different outcome for the veteran is unknown. However, addressing these issues now will help facilitate a more patient-centered environment, especially for those veterans with complex and unique medical, mental health, and psychosocial issues.

Recommendations

Recommendation 1. We recommend that medical center leadership review, and revise as needed, its policies and procedures for providing case management for veterans who have a very complex or unique mix of medical and psychosocial issues.

Recommendation 2. We recommend that medical center leadership review its coordination of care policies and practices to ensure effective communication with veterans when there are changes in their providers or care settings.

Recommendation 3. We recommend that medical center leadership work with VHA leaders to identify ways, within existing privacy laws, to improve sharing between VHA and VBA of information about unusual events impacting services.

Recommendation 4. We recommend that medical center leadership review the policies and practices of the Disruptive Behavior Committee and implement procedures to ensure that risks are communicated timely and consistently and conveyed with a patient-centered focus.

Comments

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable action plans. We will follow up on the planned actions until they are completed.

(original signed by:)

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

Medical Center and Network Directors' Comments

Department of Veterans Affairs

Memorandum

Date: November 15, 2010

From: Director, VA Medical Center

Subj: **Healthcare Inspection—Review of Quality of Care, VA Medical Center**

To: Director Healthcare Inspections (54)

1. The Leadership has reviewed the draft inspection report of the Review of Quality of Care conducted by the Office of Healthcare Inspections. Our response to the recommendations is attached.

2. We appreciate the completeness of the review that was conducted for this very complex case involving a Veteran with unique medical, mental health, and psychosocial issues. We concur with the recommendations and our action plan will promote patient-centered solutions in an effort to mitigate future high risk situations of this nature.

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommend that medical center leadership review, and revise as needed, its policies and procedures for providing case management for Veterans who have a very complex or unique mix of medical and psychosocial issues.

Response: We have reviewed the facility policy on Care/Case Management and will make the following changes:

- a. Enhance the definition of categories of Veterans that need to be evaluated for case management, i.e., suicide/homicidal risk, chronic pain, OEF/OIF Veterans, disruptive behavior flagged Veterans.
- b. Establish a formal process for planning, managing, and communicating patient's healthcare needs in an interdisciplinary setting, stipulating the identification of a clinical team who will assist in defining the appropriate care plan. Currently, several established case management programs are functioning as required by VHA, however, action will be directed toward improving communication and efficiency.
- c. Identify internal screening resources currently in place to devise the role of an oversight team to assist in identifying the case management needs of Veterans meeting the criteria for this level of support. Identify a liaison for the Veteran who will be in charge of their care coordination. Primary care is often designated the navigator for these types of complex Veteran situations.

Target Completion Date: December 31, 2010

- d. Create a central registry of all Veterans assigned to a Case Manager to include information regarding reason for case management, name of case manager, and other pertinent information as defined by the oversight team.

Target Completion Date: January 31, 2011

Recommendation 2. We recommend that medical center leadership review its coordination of care policies and practices to ensure effective communication with Veterans when there are changes in their providers or care settings.

Response: Conduct a Healthcare Failure Mode Effect Analysis (HFMEA) to review the current processes of communication with Veterans when there are changes in their providers or care settings. Recommendations from the HFMEA will be tracked to completion by the Patient Safety Manager and reported thru the Quality Improvement Forum to the Executive Committee of the Governing Body.

Target Completion Date: February 28, 2011

Recommendation 3. We recommend that medical center leadership work with VHA leaders to identify ways, within existing privacy laws, to improve sharing between VHA and VBA of information about unusual events impacting services.

Response: The VA Medical Center Director and VBA Director meet monthly to discuss operational issues. At the next monthly meeting, the Privacy Officer will be invited to discuss ways to improve sharing with the clinical team information and actions taken by VBA that could significantly impact the clinical care of a Veteran and his/her ability to deal with this type of change.

Target Completion Date: January 31, 2011

Recommendation 4. We recommend that medical center leadership review the policies and practices of the Disruptive Behavior Committee and implement procedures to ensure that risks are communicated timely and consistently and conveyed with a patient-centered focus.

Response: Executive Committee of the Governing Body (ECGB) will request the Disruptive Behavior Committee do a SWOT (Strengths/Weaknesses/ Opportunities/Threats) Analysis on their process and submit their recommendations to the ECGB on how to improve the referral process, including enhancement of the risk assessment process and ways to improve the communication with Veterans in these situations.

Target Completion Date: January 31, 2011

OIG Contact and Staff Acknowledgments

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