Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-01809-163

Combined Assessment Program Summary Report

Evaluation of Coordination of Care in Veterans Health Administration Facilities

March 31, 2015

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections completed an evaluation of coordination of care in Veterans Health Administration facilities. The purpose of the review was to evaluate discharge planning for Veterans Health Administration inpatients with the following selected post-discharge needs: (1) special diet, (2) weight monitoring, (3) wound care, and (4) prosthetics (supplies and/or equipment).

We conducted this review at 50 Veterans Health Administration medical facilities during Combined Assessment Program reviews performed across the country from October 1, 2013, through September 30, 2014.

Although we observed many positive practices, we identified four opportunities for Veterans Health Administration facilities to improve. We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility leaders, ensure that:

- Clinicians provide and document discharge instructions for all identified needs.
- Clinicians reassess patients' learning needs prior to providing important instructions, including discharge instructions.
- Clinicians reconcile conflicting needs and instructions before discharging patients.
- Patients receive ordered post-discharge referrals.

Comments

The Interim Under Secretary for Health concurred with the findings and recommendations. (See Appendix A, pages 6–12, for the full text of the comments.) The implementation plans are acceptable, and we will follow up until all actions are completed.

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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections evaluated coordination of care in Veterans Health Administration (VHA) facilities. The purpose of the review was to evaluate discharge planning for VHA inpatients with the following selected post-discharge needs: (1) special diet, (2) weight monitoring, (3) wound care, and (4) prosthetics (supplies and/or equipment).

Background

Inadequate discharge planning for the transition from hospital to home can result in an increase in hospital readmissions, adverse events, and other undesirable outcomes. According to the Agency for Healthcare Research and Quality, nearly 20 percent of patients experience adverse events within 3 weeks of discharge, nearly three-quarters of which could have been prevented. Adverse drug events and procedural complications are common post-discharge events causing considerable morbidity. Since nearly 20 percent of Medicare patients are re-hospitalized within 30 days of discharge, minimizing post-discharge adverse events has become a priority for the U.S. health care system.[1]

Root causes for ineffective transitions of care include breakdowns in communication, patient education, and accountability.[2] Patient education is particularly critical as patients or family members may receive conflicting recommendations, confusing medication regimens, and unclear instructions about follow-up care. Patients may lack a sufficient understanding of the medical condition or the plan of care; as a result, they may not internalize the importance of following the care plan or may lack the knowledge or skills to do so.

The Joint Commission established several relevant standards to guide safe discharge planning:

- The facility has a process that addresses patients' needs for continuing care, treatment, and services after discharge. Prior to discharge, the facility arranges the services required by the patient after discharge in order to meet his or her ongoing needs for care and services.
- The facility performs a learning needs assessment for each patient and evaluates the patient's understanding of the education and training it provided. Before the facility discharges a patient, it informs and educates the patient about his or her follow-up care, treatment, and services.

VHA requires that patients' educational needs, preferences, and readiness to learn are assessed on admission and that the electronic health records indicate when instructions

[1] http://psnet.ahrq.gov/primer.aspx?primerID=11. Accessed April 18, 2013.
[2] Joint Commission Center for Transforming Healthcare. *Hot Topics in Health Care – Transitions of Care: The need for a more effective approach to continuing patient care*, 2012.

are given to patients.[3,4] Patient health education must be coordinated to ensure consistency of content and must be reinforced by all disciplines caring for the patient.

Scope and Methodology

We performed this review in conjunction with 50 Combined Assessment Program reviews conducted from October 1, 2013, through September 30, 2014. The facilities we visited were a stratified random sample of all VHA facilities and represented a mix of facility size, affiliation, geographic location, and Veterans Integrated Service Networks. OIG generated an individual Combined Assessment Program report for each facility. For this report, we summarized the data collected from the individual facility Combined Assessment Program reviews.

We reviewed facility policies and conversed with applicable managers and employees. Additionally, we reviewed 1,217 patients' electronic health records. Some of the patients had more than one discharge need and/or referral; therefore, denominators differ in our reported results. The requirements that relate to this review have been in place for many years, and we used 90 percent as our expectation for compliance. The patient samples within each facility were not probability samples, and thus do not represent the entire patient population of that facility. Therefore, the patient results presented in this report are not generalizable to the entire VHA.

We attempted to focus our review on patients with regular discharges from VHA facilities by excluding patients who died during the admission, were transferred to other facilities, or left the facility against medical advice. We also excluded patients who did not have any of the following discharge needs: (1) special diet, (2) weight monitoring, (3) wound care, and (4) prosthetics.

We selected these four discharge needs—special diet, weight monitoring, wound care, and prosthetics—because they are common needs within the VHA patient population. Although many patients have additional discharge needs, we limited our focus to these four for the purposes of this review. Future reviews many focus on other discharge needs.

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

[3] VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.
[4] VHA Handbook 1120.04, *Veterans Health Education and Information Core Program Requirements*, July 29, 2009.

Inspection Results

Issue 1: Patients' Learning Needs and Discharge Instructions

VHA requires all facilities to assess patients' learning needs and abilities within 24 hours of admission to acute care as part of the admission assessment. Assessments should address factors such as visual and hearing impairments, cognitive abilities, and language preferences. Clinicians generally assessed patients' knowledge and learning needs during the admission.

Discharge plans generally addressed the identified needs. When clinicians provided discharge instructions, they validated patients' and/or caregivers' understanding of the instructions. Also, while most facilities did a good job making post-discharge phone calls, the content varied from site to site, and the calls did not count as discharge instructions for the purpose of our review.

For each of the four selected discharge needs, we assessed whether the discharge plans addressed the needs and whether clinicians provided discharge instructions relevant to the needs. If clinicians provided discharge instructions, we looked for evidence that they validated the patient's or caregiver's understanding of the instructions. For patients with special diet and/or weight monitoring, we found good compliance with these items. However, for patients who required wound care and/or who had prosthetics ordered at discharge, clinicians did not always provide discharge instructions. See Table 1 below for the details regarding the electronic health record reviews for these elements.

Table 1. Discharge Plans, Discharge Instructions, and Validation of Understanding.

	Special diet	Weight monitoring	Wound care	Prosthetics
Discharge plan did not address the needs	21/1,129 (2%)	12/797 (2%)	25/351 (7%)	10/173 (6%)
Discharge instructions relevant to the needs were not provided	39/1,033 (4%)	30/745 (4%)	31/239 (13%)	18/140 (13%)
Patient's or caregiver's understanding of the instructions was not validated	33/1,013 (3%)	28/733 (4%)	15/216 (7%)	6/123 (5%)

Source: VA OIG

While not required by VHA or The Joint Commission, we reviewed patients' electronic health records for a learning needs reassessment at the time of discharge. A patient's condition can change quite significantly during the course of an admission, and it seems important to reassess and note any changes in learning abilities before providing valuable discharge instructions. Clinicians did not reassess patients' learning needs or abilities at the time that they provided discharge instructions for 297 (26 percent) of 1,151 patients' records.

We recommended that facility managers ensure clinicians provide and document discharge instructions for all identified needs and reassess patients' learning needs prior to providing important instructions, including discharge instructions, and monitor compliance.

Issue 2: Discrepancies in Needs Identified and/or Instructions Provided

VHA requires that both nurses and physicians enter discharge notes and instructions. Other disciplines involved in the patients' care, such as dietitians and wound care specialists, will also generally enter discharge notes.

We noted discrepancies between needs identified and/or instructions provided by different clinicians in 295 (24 percent) of 1,217 patients' records. Examples include:

- A physician ordered one type of diet (such as a regular diet) needed after discharge, but the dietitian's note specified a different type of diet (such as a diabetic diet).
- A wound care specialist provided detailed wound care dressing change instructions, but the physician did not follow the recommendation or order the supplies.
- A physician wrote in the discharge instructions that the patient needed home care but did not place a consult for home care, and the patient did not receive it.

These discrepancies should be resolved at discharge to avoid causing confusion for the patient or caregiver and any applicable referral agencies.

We recommended that facilities ensure clinicians reconcile conflicting instructions before discharging patients and that facility managers monitor compliance.

Issue 3: Receipt of Post-Discharge Referrals

For the following aftercare referral options, patients did not receive the service or items:

- Home with follow-up visit appointment: 104 (11 percent) of 912
- Home health agency (such as visiting nurse service): 18 (9 percent) of 192
- Home Based Primary Care: 10 (21 percent) of 47
- Community nursing home: 6 (4 percent) of 149
- Home telehealth: 34 (18 percent) of 192
- Prosthetics (large items delivered to the home, for example, bed or lift): 9 (18 percent) of 50

For some patients, clinicians ordered more than one of these referrals. When the clinician specified a timeframe for the referral, we checked to see whether the patient received the service within that timeframe. For example, a clinician ordered delivery of a Hoyer lift to a patient's home on the day after discharge, but notes show it did not arrive for 5 days. Another example is a clinic visit for a wound check specified for 3 weeks that did not occur until 3 months after discharge. The number of referrals

where a clinician specified a timeframe was small; therefore, we are not making a recommendation about the timeframe aspect.

We recommended that facility managers ensure that patients receive ordered post-discharge referrals and monitor compliance.

Conclusions

We observed many positive practices during our review, including appropriate facility policies and admission assessments of patients' learning needs. Clinicians' discharge plans generally addressed identified patient needs, and clinicians provided instructions when they ordered restricted diets or weight monitoring at discharge. However, facilities could improve coordination of care by ensuring clinicians reassess learning needs whenever they provide important instructions and provide appropriate and clear discharge instructions for all identified needs and by ensuring patients receive post-discharge referrals.

Recommendations

1. We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that clinicians provide and document discharge instructions for all identified needs and that facility managers monitor compliance.

2. We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that clinicians reassess patients' learning needs prior to providing important instructions, including discharge instructions, and that facility managers monitor compliance.

3. We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that clinicians reconcile conflicting needs and instructions before discharging patients and that facility managers monitor compliance.

4. We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that patients receive ordered post-discharge referrals and that facility managers monitor compliance.

Interim Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: March 11, 2015

From: Interim Under Secretary for Health (10)

Subject: **Office of Inspector General (OIG) Draft Report, Combined Assessment Program (CAP) Summary Report: Evaluation of Coordination of Care in Veterans Health Administration Facilities (2015-01809-HI-0567) (VAIQ 7574127)**

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review the draft OIG CAP Summary Report: Evaluation of Coordination of Care in VHA Facilities.

2. I concur with the report and the recommendations. Attached is VHA's corrective action plan for recommendations 1 through 4.

3. Should you have any questions, please contact Karen M. Rasmussen, MD, Director, Management Review Service (10AR) at VHA10ARMRS2@va.gov.

Carolyn M. Clancy, MD

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report, Combined Assessment Program Summary Report – Evaluation of Coordination of Care in VHA Facilities

Date of Draft Report: 2/11/2015

Recommendations/ Actions	Status	Completion Date

OIG Recommendations

Recommendation 1. We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that clinicians provide and document discharge instructions for all identified needs and that facility managers monitor compliance.

Concur

VHA Comments

All members of the health care team, as appropriate, are responsible for screening and assessing Veteran inpatients for discharge planning needs, participating in team conferences and the development of interdisciplinary care planning goals, providing health education relative to their respective expertise, and documenting their discharge planning activities. However, Nursing Service is responsible for coordinating and providing written instructions to the Veteran prior to discharge and, as requested directly to or through the medical power of attorney, or personal support person. Strategies to ensure clinicians provide needed discharge instructions include discussion at team meetings and completion of the discharge checklist.

Actions to address this recommendation are:

1. VHA will conduct a series of information calls to key leaders and clinicians reinforcing policy requirements underlying recommendations 1–4 of this action plan.
2. Facilities will be provided with tools to assist in proactive discharge planning by the interdisciplinary health care team for inpatient Veterans.
3. VHA will implement a standardized process for facility and Veteran Integrated Service Network (VISN) Directors to assess and report local compliance with policy requirements identified in recommendations 1–4.

VHA requires 85 percent compliance with the requirement that clinicians provide and document discharge instructions for all identified needs. To accomplish this, team meetings will be held.

1. Through the Office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM), the Office of Nursing Services (ONS) will release a memorandum requiring VISN Directors to ensure facilities conduct quarterly record reviews of a representative sample of records of patients that were discharged until 85 percent compliance is met for the quarter. The record reviews will assess for documentation to ensure team communication is demonstrated, at a minimum the day prior to discharge (or the business day before discharge).

VHA requires 100 percent compliance with the requirement that a process is developed for facility managers to monitor compliance.

1. Through the Office of the DUSHOM, ONS will release a memorandum requiring VISN Directors to ensure facilities develop a process for facility managers to monitor compliance. ONS recommends reports from monitoring of compliance with this documentation standard are submitted to facility Quality Management for additional action as needed.

To complete this action, ONS will provide the following documentation:
1. VISN reporting that demonstrates 85 percent of records reviewed at each facility contain required documentation.
2. VISN Attestation results demonstrating that 100 percent of facilities have documented how monitoring of documentation compliance will occur and how it will be reported at the local level.

Status:	Target Completion Date:
In Process	February 2016

Recommendation 2. We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that clinicians reassess patients' learning needs prior to providing important instructions, including discharge instructions, and that facility managers monitor compliance.

Concur

VHA Comments

VHA has processes in place that are consistent with The Joint Commission relevant standards to assess patient's educational needs, preferences, abilities, and readiness to learn on admission. This information is captured during the nursing admission process, is available to all clinicians involved in the care, and may also be discussed in team meetings, especially if there is a change in condition that requires revised approaches to teaching. When discharge planning indicators are present, team members also

complete their respective discipline-specific screening and/or assessment to determine and make recommendations regarding the patient's specific discharge planning and educational needs. Teach back is used to verify patient's understanding and ability to carry out instructions.

Actions to address this recommendation are:

VHA requires 80 percent compliance with the requirement that clinicians provide and document education and discharge instructions in an effective way for all identified needs. To accomplish this, the following process will be used.

1. Through the Office of the DUSHOM, ONS will release a memorandum requiring VISN Directors to ensure facilities conduct quarterly record reviews of a representative sample of records of patients that were discharged until 80 percent compliance is met for the quarter. The record reviews will assess for documentation of an effective response to teaching (e.g. teach back) to ensure educational needs are met.

VHA requires 100 percent compliance with the requirement that a process is developed for facility managers to monitor compliance.

1. Through the Office of the DUSHOM, ONS will release a memorandum requiring VISN Directors to ensure facilities develop a process for facility managers to monitor compliance. ONS recommends reports from monitoring of compliance with this documentation standard are submitted to facility Quality Management for additional action as needed.

To complete this action, ONS will provide the following documentation:
1. VISN reporting that demonstrates 80 percent of records reviewed at each facility contain required documentation.
2. VISN Attestation results demonstrating that 100 percent of facilities have documented how monitoring of documentation compliance will occur and how it will be reported at the local level.

Status:	Target Completion Date:
In Process	February 2016

Recommendation 3. We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that clinicians reconcile conflicting needs and instructions before discharging patients and that facility managers monitor compliance.

Concur

VHA Comments

There may be many ways to resolve these issues. Each facility will identify a process to reconcile conflicting needs and instructions. Some suggested strategies include team

meetings; implementation of a systematic, organized approach to coordination of care such as Project Red© (RED) from the Agency of Healthcare Research & Quality (AHRQ), the Care Transitions Intervention® (CTI), the Transitional Care Model (TCM), or similar frameworks; and use of the Daily Plan or a similar tool. The RED toolkit includes the steps and considerations for implementing a re-engineered discharge and when followed, improves coordination of care and patient safety.

Actions to address this recommendation are:

VHA requires 80 percent compliance with the requirement that clinicians reconcile conflicting needs and instructions before discharging patients. To accomplish this, facilities will implement a plan to improve team communication and coordination.

1. Through the Office of the DUSHOM, ONS will release a memorandum requiring VISN Directors to ensure facilities conduct quarterly record reviews of a representative sample of records of patients that were discharged until 80 percent compliance is met for the quarter. The record reviews will assess for documentation of team communication and coordination (e.g. team meetings, asynchronous or non face-to-face team messaging), at a minimum the day prior to discharge (or the business day before discharge).

VHA requires 100 percent compliance with the requirement that a process is developed for facility managers to monitor compliance.

1. Through the Office of the DUSHOM, ONS will release a memorandum requiring VISN Directors to ensure facilities develop a process for facility managers to monitor compliance. ONS recommends reports from monitoring of compliance with this documentation standard are submitted to facility Quality Management for additional action as needed.

VHA requires 100 percent compliance with the requirement that facilities develop a plan to improve team communication and coordination.

1. Through the Office of the DUSHOM, ONS will release a memorandum requiring VISN Directors to ensure facilities develop a plan to improve team communication and coordination and present that plan to the VISN Director. This plan will include a process for how the facility will monitor implementation of the plan.

To complete this action, ONS will provide the following documentation:

1. VISN reporting that demonstrates 80 percent of records reviewed at each facility contain required documentation.
2. VISN Attestation results demonstrating that 100 percent of facilities have documented how monitoring of documentation compliance will occur and how it will be reported at the local level.

3. VISN Attestation results demonstrating that 100 percent of facilities have presented a plan to the VISN Director to improve team communication and coordination.

Status:	Target Completion Date:
In Process	February 2016

Recommendation 4. We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that patients receive ordered post-discharge referrals and that facility managers monitor compliance.

Concur

VHA Comments

VHA respects the patient's option to decline discharge referrals that they do not want. For those patients that do desire the ordered referrals, using a systematic, organized approach to coordination of care provides checks and balances to minimize omissions or delays in post-discharge referrals. The planning process that cues early notification to referral sources and validates discharge referrals are made prior to discharge improves adherence to orders. Information about the status of referrals should be available to the outpatient provider and staff that will be taking over care after VHA hospital discharge, as well as staff from the Fee Office, home telehealth, or others involved in the care and may also be used to inform the content of the post-hospitalization phone call to verify referral orders are fulfilled or cue follow-up actions (e.g. supplies/equipment received, home health started for wound care, intravenous medications/supplies received, home telehealth services initiated). Patients and personal support person(s) are informed about the next steps in care, including referrals through the discharge instructions.

Actions to address this recommendation are:

1. ONS will solicit the field for strong care coordination practices, tools and resources (e.g. team communication strategies, discharge planning checklist) that highlights accuracy and completion of referrals and publicize this content on VA Pulse or a similar forum.

VHA requires 85 percent compliance with the requirement that clinicians reconcile conflicting needs and instructions before discharging patients.

1. Through the Office of the DUSHOM, ONS will release a memorandum requiring VISN Directors to ensure facilities conduct quarterly record reviews of a representative sample of records of patients that were discharged until 85 percent compliance is met for the quarter. The record reviews will assess for documentation of a) team communication and coordination of referrals (e.g. team meetings, asynchronous or non face-to-face team messaging) at a minimum the day prior to discharge (or the business day before discharge) and, b) that

patients received the ordered post-discharge referrals when that care is provided by VHA.

VHA requires 100 percent compliance with the requirement that a process is developed for facility managers to monitor compliance.

1. Through the Office of the DUSHOM, ONS will release a memorandum requiring VISN Directors to ensure facilities develop a process for facility managers to monitor compliance. ONS recommends reports from monitoring of compliance with this documentation standard are submitted to facility Quality Management for additional action as needed.

VHA requires 100 percent compliance with the requirement that facilities develop a plan to improve referral accuracy and completion.

1. Through the Office of the DUSHOM, ONS will release a memorandum requiring VISN Directors to ensure facilities develop a plan to ensure that patients receive ordered post-discharge referrals provided by VHA and present that plan to the VISN Director. This plan will include a process for how the facility will monitor implementation of the plan.

To complete this action, ONS will provide the following documentation:

1. VISN reporting that demonstrates 85 percent of records reviewed at each facility contain required documentation.
2. VISN Attestation results demonstrating that 100 percent of facilities have documented how monitoring of documentation compliance will occur and how it will be reported at the local level.
3. VISN Attestation results demonstrating that 100 percent of facilities have presented a plan to the VISN Director to improve accuracy and completion of referrals.

Status:	Target Completion Date:
In Process	February 2016

Office of Inspector General
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