Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04547-401

Healthcare Inspection
Quality and Coordination of Care Concerns at Two Veterans Integrated Service Network 15 Facilities

June 25, 2015

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by a complainant regarding the quality and coordination of care of a patient at the Kansas City VA Medical Center (VAMC), Kansas City, MO, and the Kirksville VA Clinic, which is assigned to the Harry S. Truman Memorial Veterans' Hospital, Columbia, MO.

We substantiated that the patient experienced multiple hip dislocations following hip replacement surgery but note that this is a recognized complication of the procedure. We found that when the orthopedic surgery team revised the patient's left hip replacement, the patient's issues with recurrent hip dislocations resolved. Additionally, the VA National Center for Patient Safety found no safety reports from VA facilities or recall postings to VA facilities related to the early failure of the model hip implant placed in this patient, with a specific focus on the liner.

We did not substantiate that the Kansas City VAMC delayed payment for ambulance transportation associated with the patient's hip dislocations and found that payments were made by VA upon the receipt of the ambulance bills.

We substantiated that the patient's pre-operative evaluation for potential aortic aneurysm repair was delayed, but we did not substantiate that the patient's aortic aneurysm probably resulted in his death or that the VA providers inappropriately postponed repair of the aneurysm.

We substantiated that the patient did not receive appropriate evaluation for his complaints of recurrent falls and weakness during his care at the Kansas City VAMC. We found that the patient's primary care provider did not follow usual practice in prescribing medications associated with increased risk in an elderly population and did not consistently document medication reconciliation.

We could not substantiate that the patient was involved in a motor vehicle accident at a VA facility in late summer 2013. We found that VA staff documented that the patient reported falling on the VA grounds; however, we found no VA report of a motor vehicle accident for the specified date.

We substantiated that prescriptions were mailed to the patient following the patient's death, and we found that the Consolidated Mail Outpatient Pharmacy was not notified of the patient's death until after the medications had been mailed. We were told this was because Consolidated Mail Outpatient Pharmacies do not have access to data files to independently verify whether or not a veteran is deceased. Therefore, we reviewed pharmacy data files to determine whether medications were being dispensed after the date of death for patients across Veterans Health Administration. We found that 17.2 percent of patients, or 29,173 patients, who died between July 1, 2013, to June 30, 2014, were dispensed at least one prescription after death. Medications were dispensed an average of 33 days after a patient's death, and 96 percent of medications dispensed after the date of death were for non-controlled substances.

We could not substantiate the allegation that the patient was denied care three times at the Kirksville CBOC.

We recommended that: (1) the Interim Under Secretary for Health take steps to prevent prescriptions from being dispensed to deceased veterans; (2) the Kansas City VAMC Director strengthen processes for interfacility coordination of care and communication; (3) the Kansas City VAMC Director ensure that processes be strengthened so medication reconciliation is consistently completed; (4) the Kansas City VAMC Director conduct peer reviews of this patient's care, to include evaluation and treatment of recurrent falls and the coordination of care; and (5) the Harry S. Truman Memorial Veterans' Hospital Director strengthen processes for interfacility coordination of care and communication.

Comments

The Interim Under Secretary for Health and Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes A, B, and C pages 15–23 for the full text of the Interim Under Secretary's and Directors' comments.) We will follow up on the planned actions until they 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 conducted an inspection to assess the merit of allegations made by a complainant regarding the quality and coordination of care for a family member over a period of many years at the Kansas City VA Medical Center (KC VAMC), Kansas City, MO, and the Kirksville VA Clinic, which is assigned to the Harry S. Truman Memorial Veterans' Hospital, Columbia, MO.

Background

VA Facilities. VA facilities are organized into 21 Veterans Integrated Service Networks (VISN) located throughout the United States. One of these VISNs, the VA Heartland Network (VISN 15), provides health care services to patients in Kansas and Missouri, as well as parts of Arkansas, Illinois, Indiana, and Kentucky. It includes 9 campuses and 43 community based outpatient clinics (CBOCs) in 6 states (Arkansas, Illinois, Indiana, Kansas, Kentucky, and Missouri).[1]

The Kansas City VA Medical Center (KC VAMC), Kansas City, MO, a VISN 15 facility, is a 157-bed medical, surgical, and psychiatric facility. As a referral center, it provides comprehensive health care for veterans in Kansas, western Missouri, and northern Arkansas. In addition to the medical center, there are seven CBOCs. In fiscal year (FY) 2014, KC VAMC provided care for 45,976 unique patients and had 1,642 full-time employees.

The Harry S. Truman Memorial Veterans' Hospital (Truman VA), Columbia, MO, also a VISN 15 facility, is a general medical and surgical tertiary care teaching facility. In addition to the outpatient clinics located at the facility, Truman VA operates eight CBOCs, including the Kirksville VA Clinic. The Truman VA offers primary care, behavioral health, rehabilitation medicine, long term care, medical, and surgical specialties, including Cardiothoracic Surgery. It is a referral center for heart care services including open heart surgery. The Truman VA operates 123 beds, which include medical, surgical, acute psychiatry, long term care, and temporary residences for homeless veterans. In FY 2014, it provided care to 37,322 unique veterans and had 1,328 full-time employees.

Truman VA contracts with an outside (non-VA) health care provider to deliver care at the Kirksville Clinic, which opened in March 1999.

Allegations. In June 2014, the OIG received a letter from a complainant alleging multiple issues with access to services and care of a family member (patient) at the KC VAMC and Kirksville VA clinic over a period of almost 10 years. The allegations are summarized below:

[1] http://www.visn15.va.gov/v15/vaheartland.asp

- The patient's left total hip replacement dislocated three times.
- KC VAMC delayed paying ambulance bills.
- The patient had two aneurysms, and the KC VAMC postponed surgical repair at every opportunity probably causing his death.
- The patient passed out and fell while at the KC VAMC, and no one investigated why.
- The patient was involved in a motor vehicle accident in the KC VAMC parking lot the day he passed out.
- The patient continued to receive medications from the VA Pharmacy after his death.
- The patient was refused care at the Kirksville VA Clinic three times.

The complainant also alleged that the patient's left hip replacement components were put in at the wrong angle. However, this surgery occurred in the community at a non-VA hospital and was not paid for by VA. For this reason, we did not address this allegation.

Scope and Methodology

We conducted a site visit at the KC VAMC on September 30, 2014, and interviewed the Director, Chief of Staff, Chief of Quality Management, Chief and Associate Chief of Pharmacy, patient advocate, an orthopedic surgeon, a primary care provider (PCP), the Chief of Prosthetics, eligibility and billing staff, and other clinical and administrative staff knowledgeable about the event.

We conducted a site visit at the Truman VA on October 1, 2014, and interviewed the Director, Chief of Staff, Chief of Quality Management, two cardiothoracic surgeons, a physician assistant, Chief of Primary Care, patient advocate, and other clinical and administrative staff knowledgeable about the event.

We also contacted the VA National Center for Patient Safety (NCPS)[2] for information related to a specific model of hip implant. Additionally, we contacted the Chief Consultant, Pharmacy Benefits Management for the Veterans Health Administration (VHA).

To determine how this patient's family received prescription medications after the patient died, we reviewed Consolidated Mail Outpatient Pharmacy (CMOP) procedures regarding verification of patient death. To ascertain if this was a widespread issue, we

[2] NCPS was established to develop and nurture a culture of safety throughout VHA.

also reviewed pharmacy data files to determine whether medications were being dispensed after the date of death for patients across VHA.

We contacted the staff at the county medical examiner's office and obtained additional information regarding the details of the patient's death.

We reviewed facility policies; VHA policies, directives, and handbooks; contracts and financial information; the patient's electronic health records (EHR); quality management and safety information; police records; and other relevant documents.

We 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 Summary

The patient was a Vietnam veteran who had a history of a left total hip replacement for degenerative arthritis, bilateral knee surgeries, and a reconstruction of the left shoulder.

Prior to 2002, the patient had a total joint replacement of his left hip in the private sector. In 2002, the patient began receiving care at the KC VAMC. In 2003, the patient saw a VA orthopedic surgeon for bilateral hip pain and consideration of a total joint replacement of his right hip. In 2004, the patient again saw an orthopedic surgeon at the VA. At that time, the surgeon noted some obvious wear of the total hip replacement on the left but that the patient experienced the most significant pain from his right hip. He underwent a right total hip replacement at the VA. In 2005, the patient had a revision of the left total hip replacement at the VA.

In 2012, the patient was evaluated for potential surgery to correct an ascending thoracic aortic aneurysm.[3] While the complaint referenced two aneurysms, the patient's EHR referred to only one aneurysm.[4] The patient saw a pulmonologist, a cardiologist, and a dentist for pre-operative evaluation. As a result of these evaluations, the patient had a carotid endarterectomy for significant right-sided carotid stenosis and angioplasty with stent placement for occlusive coronary artery disease. In 2013, he received a follow-up angiogram, and EHR notes document that repair of the aneurysm was postponed because the patient was receiving anticoagulants following his cardiac stent placement. Subsequently, a cardiothoracic surgeon noted that the aneurysm did not appear to be increasing in size and recommended a follow-up angiogram rather than immediate scheduling of the procedure.

In late summer, 2013 the PCP evaluated the patient at an outpatient appointment. Two days later, an ambulance was called to the patient's home. The ambulance records indicated that a family member discovered the patient had been sick in bed for 2 days, and when they went to the patient's house, they found him on the bathroom floor. The ambulance transported the patient to a local private hospital where the patient died.

Additional details of the patient's history that are specifically relevant to the separate allegations are included in the Inspection Results section of this report (see below).

[3] A thoracic aortic aneurysm is a weakening and widening of the wall of the aorta near where it leaves the heart. When it occurs in the first part of the thoracic aorta, it is called an ascending thoracic aortic aneurysm.
[4] An EHR note described a second "borderline" aneurysm measuring 3 X 3 cm. However, for the thoracic aorta, a diameter greater than 3.5 cm is generally considered dilated, whereas greater than 4.5 cm would be considered aneurysmal.

Inspection Results

Issue 1: Hip Dislocations

We substantiated that the patient experienced multiple left hip dislocations following hip replacement surgery but note that this is a recognized complication of the procedure. We found that when orthopedic surgery staff revised the patient's left hip replacement, the patient's issues with recurrent hip dislocations resolved.

Additional History Specific to Orthopedic Surgeries

In winter 2003, the patient saw a VA orthopedic surgeon for bilateral hip pain and consideration of a total joint replacement of his right hip. He had undergone a total joint replacement of his left hip in the private sector[5] about 2 years prior to his presentation to the VA.

In early spring 2004, the patient again saw an orthopedic surgeon at the VA. The surgeon noted some obvious wear of the total hip replacement on the left but that the patient was experiencing the most significant pain in his right hip. The surgeon scheduled the patient for a right total hip replacement, which occurred within 3 weeks. In mid-spring, during a postoperative evaluation, orthopedic staff documented that the patient was doing well with his right total hip replacement and noted the uneven wear of the liner in the left hip replacement. The team's plan included a revision of the left total hip replacement after the patient recovered adequately from the surgery on his right hip.

In fall 2004, the patient informed the orthopedic team during a follow-up visit that he wanted to proceed with a revision of the left hip replacement. The surgeon documented the following: "Specifically highlighted the risk of infection and nerve damage as well as recurrent dislocation with revision surgery in addition to usual complications associated with total hip arthroplasty [replacement]. He voices understanding."

Two months later, the VA orthopedic surgeon revised the patient's left total hip replacement (approximately 4 and a half years after the first left hip surgery). Initially, the patient did well and was discharged. However, the patient returned within 2 days to the Emergency Department (ED) with the onset of severe pain in the left thigh. Radiographs revealed a dislocation of the left hip prosthesis. Orthopedic surgery staff admitted the patient and performed a closed reduction of the dislocation. The patient was discharged with follow-up scheduled in the orthopedic clinic. Just before the new year, the patient returned to the ED, again complaining of the sudden onset of severe

[5] A total hip replacement is a surgical procedure in which the cartilage and bone of a hip joint is replaced with artificial materials. The normal hip joint is a ball-and-socket joint with the top of the thigh bone (femur) functioning as the "ball" which fits into a cup-shaped part of the pelvic bone (acetabulum). In a total hip replacement, the surgeon removes the original ball and socket and replaces them with an artificial ball and socket joint. An artificial liner cushions the area between the ball and the socket.

left thigh pain. Once again, a closed reduction was performed and the patient discharged home with a brace on his left hip.

In mid-winter 2005, orthopedic staff saw the patient, recommended continued use of the brace, and also noted that a posterior approach had been used for the revision surgery. In spring, the patient removed the brace and returned to the ED with the onset of severe left thigh pain. The x-rays demonstrated a third dislocation, and the ED staff admitted the patient. Orthopedic surgery staff performed a closed hip reduction the next day but kept the patient in the hospital for an open revision of the left hip, noting that the patient was unsafe to discharge home due to the recurrent dislocations. Approximately 1 week later, orthopedic surgery staff revised the patient's left hip replacement. Subsequently, the patient's issues with recurrent hip dislocations resolved.

Findings

We substantiated that the patient experienced multiple hip dislocations following a revision of his left total hip replacement; however, we noted that this is a recognized complication of the procedure. While the use of a posterior approach to replace a hip joint increases the risk of dislocation, it is acceptable practice to use this approach. The EHR documents that the risk of hip dislocation was discussed with the patient prior to surgery. We confirmed with the NCPS that the specific model hip replacement used for this patient had not been recalled nor had the NCPS received incident reports of high rates of complication following implantation of this particular device. The patient's recurrent hip dislocations resolved after receiving an additional surgical procedure.

Issue 2: Delays in Payment for Ambulance Transport

We did not substantiate that the KC VAMC delayed payment for ambulance transportation associated with hip dislocations. We found that on three occasions, from 2004 through 2005, the patient was transported by an ambulance, and on all three occasions, the VA provided documentation that payment was made upon the receipt of the ambulance bill. VA staff outlined the process stating that if the patient is eligible, the VA will pay the ambulance bill.

For the ambulance services provided on two occasions in winter 2004, VA staff provided documentation that the ambulance company sent a bill to the patient in early 2005. In spring 2005, the patient informed VA that he planned to have his private insurance company initially pay the bill and then have VA pay the rest of the bill. In fall, the ambulance company mailed a bill for both dates of services to VA, which was paid about 1 month later.

For the ambulance services provided in spring 2005, the ambulance company also directly billed the patient. The patient brought the bill to VA in late summer. VA paid the bill, and the ambulance company confirmed that the payment was received approximately 3 weeks later.

Issue 3: Delays in Repair of the Patient's Aortic Aneurysm Causing the Patient's Death

While we substantiated that the patient's aortic aneurysm pre-operative evaluation was delayed, we did not substantiate that the patient's aortic aneurysm probably resulted in his death or that the VA inappropriately postponed repair of the aneurysm. The delay in the patient's pre-operative evaluation likely resulted because of poor coordination of care and communication between the patient, the patient's PCP, and the PCP's understanding of recommendations made by vascular surgery and cardiothoracic surgery staff.

Additional History Specific to Aneurysmal Disease

In summer 2011, the patient presented to the facility ED with weakness and almost falling, even with nurse assistance. He was admitted. A computed tomography (CT) scan of the chest performed during the hospitalization revealed a 5 centimeter (cm) ascending thoracic abdominal aortic aneurysm. The attending physician consulted Truman VA cardiothoracic surgery staff to evaluate the aneurysm but subsequently canceled the consult and consulted KC VAMC vascular surgery staff.

Two days later, KC VAMC vascular surgery staff saw the patient and noted that aneurysmal repair of thoracic aneurysms did not normally occur for aneurysms less than 6 cm. The vascular surgery staff did not recommend acute surgical intervention unless certain other health conditions existed, such as abnormalities of the aortic value or connective tissue diseases like Marfan's syndrome.[6] Repair of an aneurysm would usually be initiated at a smaller size if these conditions were present.

Based on the recommendations from vascular surgery staff, the attending physician started Lisinopril 5 milligrams (mg) per day and prednisone for gout and discharged the patient for further evaluation as an outpatient. The patient's presenting complaint of falls and weakness was attributed to his gout.

Following this admission, the patient received some additional testing to exclude underlying disorders as recommended by vascular surgery staff.

In the interim, a cardiothoracic surgeon at the Truman VA, not realizing that the Truman VA consult had been canceled, responded electronically and recommended additional testing to further evaluate the patient's operative risk. The recommended tests included an echocardiogram, left heart catheterization, dental evaluation, carotid ultrasounds, and pulmonary evaluations.

In spring 2012, the patient went to the KC VAMC thinking he had an appointment with his PCP to discuss options regarding his aneurysm. The nursing staff documented that they could not find evidence of an appointment being made or cancelled. The patient

[6] A genetic disorder that affects the body's connective tissue where the connective tissue lacks strength due to its abnormal chemical makeup.

did not see the PCP, and nursing staff recommended that the patient call the clinic the next week. Five days later, the patient's PCP entered the following note into the EHR:

> *Paitent [sic] seen by Thoracic Surgery at Columbia and no surgical intervention indicated since aneurysm <6cm in diameter and ECHO and CT angios showed aortic root wnl and no disection [sic] of aneurysm.*[7]

However, the provider did not acknowledge cardiothoracic surgery's recommendations for further testing to evaluate operative risk.

The next month, after several calls, one of the clinic nurses contacted the patient and informed him that the surgeons had reviewed his imaging studies and recommended routine follow-up rather than surgery. In early summer, the patient came to the clinic without an appointment asking what the PCP planned to do to address the aneurysm. A nurse informed him that she would ask his provider. The next day, the PCP called the patient and documented that the patient did not agree with a non-operative course; the PCP ordered a CT angiogram "at the patient's insistence." By this time, the patient had not seen his PCP for about 9 months, despite multiple intervening ED visits and telephone contacts and visits to the clinic by the patient expressing concerns about his condition.

In late summer 2012, the PCP saw the patient for the first time in almost a year. At that time, the PCP acknowledged the recommendations of cardiothoracic surgery at Truman VA and initiated a pre-operative evaluation at the patient's request. Within 2 weeks, the patient saw a pulmonologist and a cardiologist. In mid-fall, he saw a dentist for pre-operative evaluations. As a result of these evaluations, the patient had a carotid endarterectomy for significant right-sided carotid stenosis and angioplasty with stent placement for occlusive coronary artery disease by mid-winter 2013.

Following the stent placement procedure, EHR notes document that repair of the aneurysm would be postponed because the patient was receiving anticoagulants. After a spring 2013 CT scan, cardiothoracic surgery noted that the aneurysm did not appear to be increasing in size and recommended a follow-up angiogram in fall rather than immediate scheduling of the procedure.

Before the fall appointment, in late summer 2013, an ambulance was called to the patient's home, and the patient was transported to a local private hospital where the patient died. An autopsy was not completed.

Findings

Cardiothoracic surgeons told us that they had recommended pre-operative evaluation so that, should a follow-up study show progression, the surgeons could proceed with an

[7] A dissection of the aneurysm or dilation of the aortic root (where the aorta comes out of the heart) may have required urgent operative intervention.

operation immediately. No clear decision had been made to perform a surgical repair at the time of the patient's death.

The PCP did not order the full range of tests to evaluate the patient's pre-operative risk until more than 1 year after his diagnosis. The delay in ordering the tests may have been the result of poor communication between the PCP and the patient (repeated calls to the PCP asking for clarification of the PCP's plan and the provider's repeated notes documenting that operative intervention was not being pursued). The provider may not have ordered further tests based upon KC VAMC vascular surgery's initial recommendations, but those recommendations did not preclude operative intervention. Rather, they indicated that there was no need for immediate intervention.

Documentation of direct communication between the PCP and the patient was infrequent, and the patient usually received an annual appointment despite the complexity and severity of his ongoing medical problems. The EHR does not include documentation that the provider discussed the patient's wishes concerning treatment of the aneurysm until about a year after the diagnosis. At that time, the patient communicated his desire to pursue additional treatment options for the aneurysm. The PCP complied with his request and scheduled multiple pre-operative evaluations, which then occurred in a timely fashion.

We substantiated that a delay occurred in the initiation of the pre-operative evaluation. The pre-operative evaluation should have been initiated and completed in a timely manner so that the patient would be ready to go to surgery if a future CT scan demonstrated enlargement of the aneurysm sufficient to warrant surgery. However, the spring 2013 CT scan that was done after the pre-operative evaluations had been completed did not demonstrate that the aneurysm had reached a size that would require operative intervention. The cardiothoracic surgery team recommended continued follow-up with repeat CT scans to evaluate progression of the aneurysm, if any. As of late summer 2013, the vascular surgery team was continuing to pursue the plan of follow-up imaging studies to evaluate progression, if any, of the aneurysm.

Because we did not substantiate that VA providers inappropriately delayed repair of the patient's aneurysm, we do not substantiate that a delayed repair resulted in the patient's death. Further, without an autopsy, we cannot conclusively determine whether or not the patient died from a ruptured aortic aneurysm. The history of the patient being sick for days prior to his death, and his history of recurrent falls and weakness, would not suggest that rupture of an aortic aneurysm caused his death.

Issue 4. Evaluation of Falls and Medication Management

We substantiated that the patient did not receive appropriate evaluation for his complaints of recurrent falls and weakness during his care at the KC VAMC. We found that the patient's PCP did not follow usual practice in prescribing medications associated with increased risk in an elderly population and did not consistently document medication reconciliation.

Additional History Specific to Falls and Weakness

The patient presented on multiple occasions with complaints of falls and weakness. In late summer 2011, he was admitted to the facility for these complaints, which were attributed to his gout.[8] The patient's PCP saw him in follow-up, but the EHR does not include documentation that the PCP addressed the patient's falls or weakness during the follow-up visit. The patient returned to the ED in early fall and reported six falls in the past 6 months. The ED staff noted that he was orthostatic,[9] gave him intravenous fluids, and discharged him. A PCP saw him again approximately 2 weeks after the early fall ED visit. At that time, the physician stopped Lisinopril and started metoprolol 12.5 mg two times a day. He also received Flexeril at a starting dose of 10 mg three times daily for back pain.

In spring 2012, the patient returned to the ED because two primary care appointments in early and mid-winter had been canceled by the clinic. He stated his spring appointment in primary care had also been canceled and no one had notified him. He showed a nurse the appointment card. He was not seen the day he presented to the primary care clinic but obtained a late summer appointment. At the time of the late summer appointment, his PCP scheduled him for a follow-up in 1 year. While the patient continued to receive testing for pre-operative evaluation associated with his thoracic aneurysm over the next few months, the EHR contains no evidence that the patient was further evaluated for his repetitive falls and weakness.

Findings

An evaluation of the reasons for recurrent falls in older adults includes review of prescribed and over-the-counter medications. However, in late summer 2013, the PCP evaluated the patient at an outpatient appointment but did not document medication reconciliation, as required by local policy. Local policy requires that during an outpatient clinic appointment, the provider's responsibilities include a review of the medication list and verify accuracy with the patient and documentation of the reconciliation in the EHR.[10] Medication reconciliation would have been particularly important for this patient because his EHR reflected that he had been prescribed Flexeril, a medication associated with an increased risk of falls in older patients,[11] at a dose higher than the dose recommended for older adults by another provider.[12]

[8] Gout is a form of arthritis and is characterized by sudden attacks of pain, redness and tenderness in joints, often the joint at the base of the big toe.
[9] Orthostatic hypotension is a form of low blood pressure.
[10] Medication reconciliation is a process of comparing the medications a patient is taking and should be taking, with newly ordered medications. The comparison addresses duplications, omissions, and interactions and the need to continue current medications.
[11] American Geriatric Society, "Ten Medications Older Adults should Avoid or Use with Caution." http://www.americangeriatrics.org/files/documents/beers/FHATipMEDS.pdf
[12] http://www.drugs.com/dosage/cyclobenzaprine.html.

We concluded that the patient did not receive an appropriate evaluation to determine the cause of his falls or education on how to minimize his future risk of falling.

Issue 5. The Patient Was Involved in a Motor Vehicle Accident in the KC VAMC Parking Lot

We could not substantiate this allegation. The complainant stated that the family had received notification about an accident after the patient passed away and that the accident occurred at the VA late summer 2013.

We reviewed VA police and safety reports for the patient's date of care in question. We found documentation related to a fall on VA grounds but no documentation of the patient reporting a motor vehicle accident to VA staff. No one we interviewed could recall that the patient had been involved in a vehicle accident on VA grounds. The patient's EHR did not contain any reference to this alleged accident.

Issue 6: The Patient Received Medications From the VA Pharmacy After Death

We substantiated that prescriptions were mailed to the patient's home following his death. At the time of the patient's late 2013 summer appointment, his VA provider, entered orders into the EHR for medications to be mailed. Two days later, the day of the patient's death at a private medical facility, prescriptions were processed and transmitted to the CMOP

Four days after the patient's death, the mail order pharmacy mailed the prescriptions, and the next day, VA staff entered a note about receiving notification of the patient's death.

Due to the overlapping timeframe, the VA pharmacy was not aware of the patient's death. We determined that CMOPs do not routinely check social security or the Beneficiary Identification Records Locator Subsystem (BIRLs)[13] to determine whether a patient is deceased but instead rely on notification from the facilities through canceled prescriptions.

Because we were told this was the general practice for CMOPs, and to determine whether this practice resulted in significant numbers of prescriptions being dispensed to deceased patients across VHA, we reviewed national pharmacy data files. We found that 17.2 percent of patients, or 29,173 patients, who died between July 1, 2013, to June 30, 2014, were dispensed at least one prescription after death. Medications were dispensed an average of 33 days after the patient's death, and 96 percent of medications dispensed after the date of death were for non-controlled substances.

While it is beyond the scope of this review to determine the specific process change needed to prevent the dispensing of medications to deceased patients, the data reflects

[13] The BIRLS is a Veterans Benefits Administration database that lists information for deceased individuals who had received benefits from the Veterans Administration while they were alive.

that CMOPs mailed medications to nearly 1 in 5 deceased patients after their dates of death. We concluded that current procedures used by CMOPs are inadequate to prevent prescriptions from being dispensed to deceased veterans.

Issue 7. Veteran Was Refused Care at the Kirksville VA Clinic

We could not substantiate the allegation that the patient was denied care three times at the Kirksville VA Clinic. The complainant stated that when the patient visited family in Kirksville, the family called the Kirksville VA Clinic at least three times over the years and was denied care; however, we were not provided specific information about the phone calls. The patient's EHR does not include documentation from Kirksville VA Clinic staff that these contacts occurred.

A KC VAMC provider entered an EHR note in spring 2011 that stated a patient's family member called requesting a refill of medication for gout. The provider documented the family reported that they had contacted the Kirksville VA Clinic about the medication refill. The KC VAMC staff contacted a local private pharmacy for the prescription refill. The patient was not assigned to a Kirksville VA clinic provider and would have been considered a traveler.

VA policy[14] that was current in 2011 regarding coordination of care for traveling veterans provided instructions for traveling patients to request prescription refills from the preferred facility[15] through use of the automated refill request line, a refill request form, the internet refill request option in My Health***e***Vet, or by phoning the preferred facility's outpatient pharmacy during normal business hours.

In spring 2012, the Kirksville VA Clinic contract was modified to add a fee schedule for unassigned patients receiving treatment at the clinic. The new terms of the contract stated that "persons not verified eligible who present to a CBOC in need of urgent or emergent care will be treated on a humanitarian basis until stable and discharged from the CBOC." However, clinic staff told us that any patient presenting for an urgent or emergent issue would have been treated at the clinic, regardless of whether they presented before or after the terms of the new contract went into effect.

[14] VHA Directive 2007-016, *Coordinated Care Policy for Traveling Veterans*, May 9, 2007.
[15] A preferred facility is that VHA facility for which veterans express their preference as their principal location of care and at which the major portion of their primary care is provided. In this patient's case, it was the KC VAMC.

Conclusions

We substantiated that the patient had three hip dislocations after revision of his total left hip replacement at the VA. However, dislocation is a known complication of revision surgery, the patient received care for each hip dislocation, and surgery that was performed after the third dislocation resolved the problem. The VA NCPS found no safety reports from VA facilities or Recall postings to VA facilities related to the early failure of the specific model hip implant, with a specific focus on the liner.

We did not substantiate that the KC VAMC delayed payment for ambulance transportation as alleged. We found that on three occasions, from 2004 through 2005, the patient was transported by an ambulance, and on all three occasions, the VA provided documentation that payment was made upon the receipt of the ambulance bill.

We substantiated that initiation of the patient's aortic aneurysm pre-operative evaluation was delayed, but we did not substantiate that the patient's aortic aneurysm probably resulted in his death, or that the VA inappropriately postponed repair of the aneurysm.

We substantiated the patient did not receive appropriate evaluation for his complaints of recurrent falls and weakness during his care at the KC VAMC. We found that the patient's PCP did not follow usual practice in prescribing medications associated with increased risk in an elderly population and did not consistently document medication reconciliation.

We could not substantiate the allegation that the patient was involved in a motor vehicle accident at the VA. We found that VA staff documented that the patient reported falling on the VA grounds; however, we did not find documentation of the patient reporting a motor vehicle accident to VA staff in late summer 2013.

We substantiated that prescriptions were mailed following the patient's death, and we found the CMOP was not notified of the patient's death until after the medications were mailed. Because we were told that CMOPs do not independently verify whether or not a patient is deceased prior to mailing a prescription, we reviewed pharmacy data files to determine whether medications were commonly dispensed after the date of death for patients across VHA. We found that 17.2 percent of patients, or 29,173 patients, who died between July 1, 2013 to June 30, 2014, were dispensed at least one prescription after death. Medications were dispensed an average of 33 days after a patient's death, and 96 percent of medications dispensed after the date of death were for non-controlled substances. We concluded that CMOP procedures were inadequate to identify deceased patients prior to the mailing of prescriptions.

We could not substantiate the allegation that the patient was denied care three times at the Kirksville VA Clinic.

Recommendations

1. We recommended that the Interim Under Secretary for Health take steps to prevent prescriptions from being dispensed to deceased veterans.

2. We recommended that the Kansas City VA Medical Center Director strengthen processes for interfacility coordination of care and communication and monitor compliance.

3. We recommended that the Kansas City VA Medical Center Director ensure that processes be strengthened so medication reconciliation is consistently completed and monitor compliance.

4. We recommended that the Kansas City VA Medical Center Director conduct peer reviews of this patient's care, to include the evaluation and treatment of recurrent falls and the coordination of care.

5. We recommended that the Harry S. Truman Memorial Veterans' Hospital Director strengthen processes for interfacility coordination of care and communication and monitor compliance.

Appendix A

Interim Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: May 6, 2015

From: Interim Under Secretary for Health (10)

Subj: Healthcare Inspection—Quality and Coordination of Care Concerns at Two Veterans Integrated System Network 15 Facilities (VAIQ 7597014)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review the OIG draft report of the Healthcare Inspection Quality and Coordination of Care Concerns at Two Veterans Integrated Service Network 15 Facilities.

2. I concur with the findings and recommendations in the draft report and provide comments in response to recommendation 1. Comments in response to recommendation 2, 3, 4, and 5 have been provided by the Veterans Integrated Service Network Director and facility Directors respectfully.

3. Please direct questions or concerns regarding the content of this memorandum to Karen Rasmussen, MD, Director, Management Review Service (10AR) at VHA10ARMRS2@va.gov.

(original signed by:)

Carolyn M. Clancy, MD

Cc: Director, Kansas City Office of Healthcare Inspections (54KC)

Comments to OIG's Report

The following Interim Under Secretary for Health comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Interim Under Secretary for Health take steps to prevent prescriptions from being dispensed to deceased veterans.

Concur

Target date for completion: May 2016

Facility response: VA recognizes the need to improve the customer data interface to avoid duplication of effort, as well as timely processing of information such as change of address, next of kin and death. The VA Veteran Experience office in conjunction with VHA, the Veterans Benefits Administration and the National Cemetery Administration, has established the development and implementation of Customer Data Integration (CDI) as a foundational priority.

VHA concurs with the recommendation, but would like to note that information needed to ascertain the date of death may lag significantly behind prescription refills that have already been requested by a patient or his/her caregiver.

According to Data Quality Requirements for Healthcare Identity Management and Master Veteran Index Function VHA Directive 1906, "Death certificates are generally required to enter a date of death" in VA's electronic health record. Dates of death must not be entered from newspaper obituaries, phone calls, or other unofficial sources. Information from these sources may be used as a mechanism to further research the death information. However, they must not be entered unless they have been verified by an official source. Medical facilities are required to use the following as authoritative sources in order of precedence: (a) VHA facility is an authoritative source for date of death if the person died in the VHA facility or while under VA auspices (b) death certificate, and (c) National Cemetery Administration (NCA) is an authoritative source for the date of death if the Veteran has received NCA benefits.

Once a date of death is entered into the VA electronic health record, all active pharmacy prescriptions are automatically discontinued, which makes them non-refillable. The only scenarios where a date of death could have been entered and a deceased Veteran received a prescription are: (1) the prescription already entered the mail stream before the date of death was recorded, or (2) the date of death was recorded after the prescription was electronically transmitted to the Consolidated Mail Outpatient Pharmacy (CMOP) for processing. The average CMOP turn-around time for placing a completed prescription in the mail stream is 36 hours after receiving the electronic transmission.

To assist in the prevention of prescriptions from being dispensed to deceased Veterans VHA will perform an internal analysis of the data to evaluate the extent of medications being dispensed to deceased patients. Additionally, The Date of Death Process Requirements Group will analyze the current process for recording and sharing Veteran dates of death and compiling requirements for enhancing the process.

To complete this action plan, VHA will provide the following documentation:

1. Results and recommendations from the two analyses; and
2. Action plans addressing the recommendations, if any.

Appendix B

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: April 16, 2015

From: Director, VA Heartland Network (10N15)

Subj: Healthcare Inspection—Quality and Coordination of Care Concerns at Two Veterans Integrated System Network 15 Facilities

To: Director, Kansas City Office of Healthcare Inspections (54KC)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. Attached is the response from VAMC Kansas City and VAMC Columbia. I have reviewed and concur with the Interim Medical Center Director and Medical Center Director responses. Thank you for the review and its focus on continuous improvement.

2. For additional questions, please feel free to contact Mary O'Shea VISN 15 Quality Management Officer.

(original signed by:)

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

Appendix C

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: April 16, 2015

From: Director, Kansas City VAMC, Kansas City, MO (586/00)

Subj: Healthcare Inspection—Quality and Coordination of Care Concerns at Two Veterans Integrated System Network 15 Facilities

To: Director, VA Heartland Network (VISN 15)

1. Thank you for the opportunity to review the draft report of the Healthcare Inspection Quality and Coordination of Care Concerns at Two Veterans Integrated Service Network 15 Facilities conducted the week of September 30-October 1, 2014.

2. I have reviewed the document and concur with the recommendations.

3. Corrective action plans have been developed and implemented for the recommendations as outlined in the attached report.

4. If you have further questions or concerns, please contact Dr. Rebecca Cahill, Chief of Performance and Patient Care Improvement, at (816) 922-2701.

(original signed by:)

David B. Isaacks
Interim Medical Center Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 2. We recommended that the Kansas City VA Medical Center Director strengthen processes for interfacility coordination of care and communication and monitor compliance.

Concur

Target date for completion: 4/30/2015

Facility response: During fiscal year 2014, KC VAMC and Columbia VAMC implemented the following steps to strengthen processes for interfacility coordination of care and communication:

1. KC VAMC hired several RN Care Coordinators to cover all specialty areas in addition to the Primary Care "PACT" care coordination and case management RNs. Specifically, Cardiology added two RN Care Coordinators. One of the main goals was to enhance coordination of care with Primary Care and other specialties as well as interfacility referrals such as referrals to the Columbia VAMC Cardiothoracic Surgery (CTS) Program.

2. To specifically enhance communication for referrals to the Columbia VAMC CTS program, Columbia VAMC and KC VAMC established points of contact for CTS, Cardiology and Vascular Surgery Programs for both facilities.

3. A weekly teleconference was established to discuss referred cases (case conference) to enhance communication between the KC VAMC Cardiology (referring service) and Columbia VAMC CTS Service.

4. Both Chiefs of Staff communicate on a regular basis, especially for issues related to interfacility referrals, and get more directly involved when needed to ensure open communication channels among related services.

5. The KC VAMC established a consult management committee tasked with regular monitoring of timeliness, scheduling and completion of consults including interfacility consults. The VISN15 Western Orbit (including KC VAMC and Columbia VAMC) has an integrated electronic medical record system further enhancing consult communication and review of records.

Request closure for this recommendation.

Recommendation 3. We recommended that the Kansas City VA Medical Center Director ensure that processes be strengthened so medication reconciliation is consistently complete and monitor compliance.

Concur

Target date for completion: 4/30/2015

Facility response: From 2013 to now, the KC VAMC has continually worked to strengthen its medication reconciliation process through the implementation of several initiatives. In 2013, the KC VAMC developed and implemented a new medication clinical reminder. Not only did the reminder serve as a visual cue for the provider, but it also helped to assist the providers in the documentation of medication reconciliation in a variety of clinical settings. In an effort to further enhance the mediation reconciliation process, the KC VAMC developed and implemented a new note template in 2014 to complement the clinical reminder technology and assist providers with medication reconciliation during transitions of care. Furthermore, the KC VAMC submitted a proposal to the 2015 VA Employee Innovations Competition to develop a national medication reconciliation tool. The proposal was selected as a finalist in February 2015 and the KC VAMC is pursuing loading the medication reconciliation tool that was developed at the Portland VA in an integrated environment in an effort to improve medication reconciliation processes at the KC VAMC and help standardize medication reconciliation processes nationally. The KC VAMC uses EPRP and clinical reminder data to ensure compliance with medication reconciliation processes. EPRP data has shown improvement of medication reconciliation from 2013 to 2015. Request closure for this recommendation.

Recommendation 4. We recommended that the Kansas City VA Medical Center Director conduct peer reviews of this patient's care, to include evaluation and treatment of recurrent falls, and the coordination of care.

Concur

Target date for completion: 4/30/2015

Facility response: A Peer Review was initiated on 04/09/15 as recommended. Request closure for this recommendation.

Appendix D

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: April 15, 2015

From: Director, Harry S. Truman Memorial Veterans' Hospital (589A4/00)

Subj: Healthcare Inspection—Quality and Coordination of Care Concerns at Two Veterans Integrated System Network 15 Facilities

To: Director, VA Heartland Network (10N15)

1. Thank you for the opportunity to review the draft report of the Healthcare Inspection Quality and Coordination of Care Concerns at Two Veterans Integrated Service Network 15 Facilities conducted the week of September 30-October 1, 2014.

2. I have reviewed the document and concur with the recommendation.

3. Corrective action plans have been developed or implemented for the recommendation as outlined in the attached report.

4. If you have further questions or concerns, please contact Crystal Aholt, Chief of Quality Management, at (573) 814-6592.

(original signed by:)

Wade Vlosich
Medical Center Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 5. We recommended that the Harry S. Truman Memorial Veterans' Hospital Director strengthen processes for interfacility coordination of care and communication and monitor compliance.

Concur

Target date for completion: 4/30/2015

Facility response: In the last few years, several processes have been implemented that have improved the coordination of care overall. Patient navigators have been put into place in all Specialty Care clinics. As well, Cardiothoracic has three Physician Assistants to assist in consult management. Specifically for the cardiothoracic program, points of contact for referrals have been established. Consults are monitored weekly for timely and appropriate scheduling which includes interfacility consults. More recently, a consult management workgroup has also been established and is chaired by the Chief of Staff. Request closure for this recommendation.

Appendix E

OIG Contact and Staff Acknowledgements

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Larry Selzler, MSPT, Team Leader Andrea Buck, MD, JD Lin Clegg, PhD James Seitz, RN, MBA Patrick Smith, M. Stat

Appendix F

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