DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Discharge Planning Deficits for a Veteran at the Malcom Randall VA Medical Center in Gainesville, Florida

HEALTHCARE INSPECTION | REPORT #21-01695-38 | NOVEMBER 30, 2021

MISSION

The mission of the Office of Inspector General is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Report suspected wrongdoing in VA programs and operations to the VA OIG Hotline:

www.va.gov/oig/hotline

1-800-488-8244

Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess concerns about a patient with multiple medical problems at the Malcom Randall VA Medical Center (VAMC) in Gainesville, Florida. The OIG identified potential issues related to discharge planning and care coordination for a patient who died 17 days after discharge from a 33-day hospital stay at Malcom Randall VAMC. The OIG also reviewed coordination of care for the patient, including medication management, between Malcom Randall VAMC and the White River Junction VAMC in Vermont, where the veteran also regularly received care.

The Malcom Randall VAMC's interdisciplinary team (IDT) failed to develop a discharge plan that adequately ensured patient safety and continuity of care. The Malcom Randall VAMC did not have a discharge planning policy that outlined IDT membership, communication expectations, or roles in discharge planning. Moreover, the Malcom Randall VAMC's IDT structure did not consistently support some clinical disciplines, including providers in physical therapy and occupational therapy, to actively participate in IDT rounds.[1]

Physical therapy and occupational therapy providers repeatedly assessed the patient's function as below baseline during the 33-day hospitalization. The occupational therapy provider documented, in a progress note, safety concerns and a change in discharge recommendations. However, the occupational therapy provider's progress note was unsigned, and therefore the information was not visible to the attending physician or IDT members.[2] The OIG found that the occupational therapy provider did not verbally communicate the new recommendation or take action to stop the discharge until the safety concerns were addressed. The OIG could not specifically determine why these actions were not taken, but the OIG found this to be an example of ineffective IDT communication and coordination practices.

The OIG also found that an attending physician failed to review written recommendations from consultative and ancillary providers before composing the discharge plan for the patient. For example, the occupational therapy provider recommended a home health occupational therapy safety assessment, as well as home health occupational therapy and physical therapy, and the infectious disease specialist recommended home wound care, but neither of these were incorporated into the patient's discharge plan. In an interview with the OIG, the attending physician could not recall seeing any recommendations for a consult to be placed for home health services. The Chief of Medicine told the OIG during an interview that if home health services were not ordered at the time of discharge, it might have been an oversight.

[1] The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[2] According to Health Information Management Service, unsigned progress notes are not visible to other team members.

The OIG determined that social workers did not consistently complete thorough and detailed psychosocial assessments or follow up on clinical information that would be pertinent to discharge planning. For example, the patient's home was self-described as a "shack," but the social workers did not ask important questions about the condition of the home, such as whether it had a method for providing cooling during warmer conditions, whether it had stairs, or whether it was cluttered. This information would have been useful in determining whether the residence was a suitable environment for discharge after the patient's hospitalization. Additionally, a social worker did not document the reason the patient wished to stay in the hospital for four days after being medically cleared for discharge or clarify the patient's intended date to return to Vermont or how the patient planned to get there. This information was necessary to determine whether the patient's plan was safe and feasible, as well as the expected time that the patient would still be in Florida and requiring home health or other support services. When asked by the OIG, the social worker did not recall the details of the case and could not provide any clarification as to why assessments were not consistently completed.[3]

The social worker, who had significant responsibility for ensuring the adequacy and safety of the patient's discharge plan, also failed to incorporate recommendations by the occupational therapy provider for the home health occupational therapy safety assessment and failed to discuss and offer home health services to manage the patient's venous leg ulcer and monitor infection of the right leg. The social worker acknowledged during an interview that it was an oversight to not review and follow up on the recommendations from the occupational therapy provider.

Although the Malcom Randall VAMC's Chief of Social Work, social work supervisor, and social worker all stated or implied that the patient's right to make decisions and decline services was a factor in discharge planning, the OIG determined that none of the patient's statements or intentions—including refusal of physical therapy, desire to be discharged home, or plan to go back to Vermont—obviated the need for adequate and safe discharge planning. Further, refusal of physical therapy did not constitute a blanket refusal of other services.

The care coordination between the Malcom Randall VAMC and the White River Junction VAMC was generally adequate and followed Veterans Health Administration guidelines. The Malcom Randall VAMC's traveling veteran coordinator initiated a comprehensive interfacility consult in preparation for the patient's discharge. However, despite finding adequate communication between the facilities' traveling veteran coordinators, the OIG team determined the communications between a Malcom Randall VAMC pharmacist and a White River Junction VAMC pharmacist regarding discontinuation of the patient's apixaban was inadequate. In accordance with established policy, a Malcom Randall VAMC pharmacist sent an encrypted email containing the appropriate information to an outpatient pharmacy group email address with

[3] Due to COVID-19 precautions, the social worker only communicated with the patient over the telephone and did not assess the patient in person during the 33-day hospital stay.

"Cancel RX [prescription]" in the subject line. While a White River Junction VAMC pharmacist told the OIG that they were unable to open the encrypted email, the OIG noted that no apparent effort was made to follow up with the Malcom Randall VAMC pharmacist regarding the content of the email. While the apixaban was automatically refilled per the 90-day schedule, the OIG team did not find evidence that the patient took the medication. The OIG notified the White River Junction VAMC's Director of this concern.

The OIG made five recommendations to the Malcom Randall VAMC Director related to roles and responsibilities of IDT members, communication of changes in patient care recommendations between providers, and a review of the care rendered to the patient by providers involved in discharge planning.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations 1–5. Acceptable action plans were provided (see appendix B for the Directors' comments). The OIG considers all recommendations open and will follow up on the planned actions until they are completed.

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

Contents

Abbreviations

ADL	activities of daily living
EHR	electronic health record
IADL	instrumental activities of daily living
IDT	interdisciplinary team
MSSA	methicillin-susceptible staphylococcus aureus
OIG	Office of Inspector General
VAMC	VA Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess concerns regarding the adequacy of discharge planning for a patient with multiple medical problems at the Malcom Randall VA Medical Center (VAMC) in Gainesville, Florida. The OIG also reviewed coordination of care for this patient, including medication management between the Malcom Randall VAMC and the White River Junction VAMC in Vermont.

Background

The Malcom Randall VAMC, part of Veterans Integrated Service Network (VISN) 8, is a tertiary care facility that provides a full range of patient care services to veterans in North Florida/South Georgia. Malcom Randall VAMC, Gainesville, Florida; and Lake City VAMC, Lake City, Florida; comprise the North Florida/South Georgia Veterans Health System. The Malcom Randall VAMC is classified by the Veterans Health Administration (VHA) as complexity level 1a.[1] From October 1, 2019, through September 30, 2020, the Malcom Randall VAMC served 112,715 unique patients and had a total of 611 hospital operating beds including 314 inpatient beds, 76 domiciliary beds, and 221 community living center beds. In addition, the North Florida/South Georgia Veterans Health System operates 12 community-based outpatient clinics in Florida and Georgia.

The White River Junction VAMC, part of VISN 1, is an acute care facility providing a full range of primary, secondary, and specialty care, and provides health care services to patients in Vermont and the four contiguous counties in New Hampshire. The White River Junction VAMC is classified by VHA as level 2 complexity. From October 1, 2019, through September 30, 2020, White River Junction VAMC served 21,891 unique patients and had a total of 76 hospital operating beds including 62 inpatient beds and 14 domiciliary beds. In addition, the White River Junction VAMC operates seven community-based outpatient clinics in New Hampshire and Vermont.

[1] The VHA Facility Complexity Model categorizes medical facilities based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3, with Level 1a facilities being the most complex and Level 3 facilities being the least complex. "Facility Complexity Model," VHA Office of Productivity, Efficiency and Staffing.

Care Coordination

VHA fulfills its commitment to providing the highest standard of patient care by ensuring that VA medical facilities maintain accreditation by The Joint Commission.[2] The provision of care, treatment, and services to patients in the hospital is one area where VA medical facilities are evaluated by The Joint Commission during the accreditation process.

When a patient enters the hospital, medical professionals such as physicians, nurses, pharmacists, social workers, dietitians, therapists, and home care coordinators work together as an interdisciplinary team (IDT) to provide safe, quality care.[3] Standards set by The Joint Commission for patient care include

- the provision of continuous and comprehensive care based on a patient's condition,
- a team-based approach and the use of a multidisciplinary team to provide care, and
- the use of internal and external resources to meet patient needs.

VHA also utilizes traveling veteran coordinators who help organize care between a patient's primary VHA care site and an alternate VHA facility where the patient may be on extended travel.[4]

Therapy Services

Physical therapy providers develop treatment plans to improve a patient's mobility, reduce or manage pain, restore function, and prevent disability.[5] Occupational therapy providers create plans that concentrate on strategies to improve a patient's ability to perform activities of daily living (ADLs) and instrumental ADLs (IADLs). ADLs are basic functions such as feeding, personal hygiene, toileting, dressing, and functional mobility. IADLs are more complex tasks such as driving, financial and medication management, meal preparation, shopping, housekeeping, and communicating with others.[6] After acute hospitalization, some patients may

[2] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. The Joint Commission is an independent, not-for-profit group that evaluates and accredits more than 22,000 health care organizations and programs in the United States using detailed standards to assess the delivery of safe and effective health care to the public.

[3] David Reuben et al. "Interdisciplinary Team Care" accessed July 7, 2021, https://pogoe.org/productid/21709. A group of healthcare professionals with various areas of expertise who work together to care for patients are also referred to as an interdisciplinary team.

[4] VHA Directive 1101.11(3), *Coordinated Care for Traveling Veterans*, April 22, 2015 (amended July 20, 2017). The traveling veteran coordinator at a facility is a registered nurse, physician's assistant, nurse practitioner, or physician.

[5] The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[6] Peter Edemekong et al., "Activities of Daily Living," In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing (updated June 26, 2020), accessed May 17, 2021, https://www.ncbi.nlm.nih.gov/books/NBK470404/.

not be able to return to their previous functional and activity levels due to continued debility. In these cases, patients may require admission to a short-term rehabilitation facility where they can receive physical therapy and occupational therapy, or arrangements may be made for physical therapy and occupational therapy service delivery in the patient's home. Other skilled home health services include wound care to treat injuries or infections of the skin, intravenous therapy, and injections.

Areas of Concern

The OIG identified potential issues related to discharge planning and care coordination for a patient who died 17 days after discharge from a 33-day hospital stay at the Malcom Randall VAMC. This review focused on the adequacy of

- discharge planning, which for the purpose of the review included IDT communication and coordination, as well as social work discharge planning activities; and
- care coordination between the Malcom Randall VAMC and the White River Junction VAMC, which for the purpose of the review included communication between traveling veteran coordinators and between pharmacy staff members.

Scope and Methodology

The OIG initiated the inspection on March 3, 2021, and conducted a virtual site visit April 12–21, 2021. Follow-up interviews were conducted from May 10–June 10, 2021. The OIG team interviewed staff from the Malcom Randall and the White River Junction VAMCs including the Chiefs of Staff, traveling veteran coordinators, physicians, pharmacists, and social workers. Interviewees from the Malcom Randall VAMC also included the Chiefs of Medicine, Pharmacy, and Social Work; quality management staff; and staff involved in the patients' care including nurse managers, occupational therapists, and a wound care nurse.[7] The Chief of Primary Care at the White River Junction VAMC was also interviewed. The OIG team reviewed relevant VHA directives and handbooks; relevant Malcom Randall VAMC and White River Junction VAMC policies including anticoagulation therapy management, coordination of care for traveling veterans, discharge planning, and disclosure of adverse events to patients; and other quality and clinical practice documents. In addition, the OIG team reviewed the patient's electronic health record (EHR).

[7] The OIG team attempted to reach the resident physician involved in the care of the patient; however, the resident had since transferred to another VA facility. After discussion by the team, the determination was made that the resident physician would be unlikely to provide additional material insight into the care of the patient that was not reflected in the EHR or obtained during other staff interviews. In addition, the attending physician was responsible for the overall care of the patient.

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1101, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

Patient Case Summary

The patient was in their 60s with a history of high blood pressure, type 2 diabetes, hyperlipidemia, diastolic heart failure, atrial fibrillation, coronary artery disease, mitral valve repair, chronic obstructive pulmonary disease, obesity, benign prostatic hypertrophy, venous stasis, and lymphedema.[8] The patient was a "traveling veteran" who was normally followed by a primary care provider at White River Junction VAMC but received care as needed at Malcom Randall VAMC.[9]

Early Spring 2020 Hospitalization

In early spring 2020, the Malcom Randall VAMC admitted the patient for swelling in the legs and a skin infection. The patient received treatment for the medical conditions and was discharged after 12 days of hospitalization. The discharge instructions reflected the patient was safe for discharge with follow-up from primary care, cardiology, home wound care, and continued physical therapy. Treatment of the patient's medical problems resulted in the Malcom Randall VAMC provider discontinuing the patient's apixaban. The patient received wound care at home through a community-based home health agency. The patient declined a primary care follow-up appointment at the Malcom Randall VAMC due to "feeling better."

In mid-spring, the patient notified providers at the White River Junction VAMC about a recent hospital admission and requested that the primary care provider review the patient's EHR and assist remotely. According to the EHR, the patient referenced a concern about swollen legs due

[8] The patient had surgery to bypass blocked arteries several years before the 2020 hospitalizations.
[9] From October 2017 to April 2020, the White River Junction VAMC anticoagulation clinic monitored the patient, including via telephone calls while the patient was in Florida, as the patient was being prescribed apixaban, an anticoagulant. The pharmacy mailed the apixaban to the patient in Florida, as needed, to continue anticoagulation treatment. During this time, the patient did not have any medical problems with apixaban.

to a prescribed blood thinner and was "hoping for an antibiotic." A White River Junction VAMC patient aligned care team member returned the patient's call three days later and left a voice message regarding several clinic appointments at the White River Junction VAMC in late spring.

Spring 2020 Hospitalization

One month after discharge from the 12-day hospitalization, the patient was readmitted (hospital day one) to the Malcom Randall VAMC for diastolic heart failure, worsening swelling in the lower legs, a skin infection in the right leg, a low red blood cell count, and other chronic medical problems. The medicine team consulted an infectious disease specialist, wound care, occupational therapy, physical therapy, and social work services. The patient was placed on intravenous antibiotics for methicillin-susceptible staphylococcus aureus (MSSA), with the EHR noting "bacteremia likely from cellulitis" on right lower leg because the wound cultures also grew MSSA. Medical tests did not find pneumonia, a mass in the abdomen, or deep vein thrombosis in the lower legs.

About a week after admission, on hospital day eight, the patient was transferred to the medical intensive care unit for low blood pressure, rapid heart rate, and a drop in hemoglobin, which required a blood transfusion. Multiple evaluations and medical procedures did not identify the source of the patient's bleeding.[10] A hematology consult revealed an acquired factor VIII deficiency/hemophilia A. The acquired hemophilia was suspected to be the cause of the acute blood loss. On hospital day 17, a social worker wrote "Veteran has a stated goal to go home when medically stable and writer suspects this may not meet [patient's] level of care needs." After 11 days in the intensive care unit, the patient improved and returned to the medical floor on hospital day 19.

Over the next week, the patient received continued treatment for swelling in the lower legs, and the EHR reflected that the patient's bleeding had resolved. The patient refused to participate in physical therapy, reporting it was too painful. On hospital day 19, a physical therapy provider noted "Unable to fully assess functional capacity. Per initial eval [evaluation] pt [patient] lives in a shack and is going to move back to Vermont. I foresee there being difficulties safely achieving either of these; however, pt [patient] is refusing PT [physical therapy] services." While the patient agreed to placement in the facility's community living center to complete the intravenous

[10] Specialized imaging of the patient's abdomen did not find an active bleed but was suggestive of a kidney infection and the antibiotics were changed by an infectious disease specialist to cover this infection. A specialist in the disorders of the stomach and intestines evaluated the condition and did not identify a source of bleeding but did find a collection of blood in the throat. Specialized imaging of the neck demonstrated thickening in the throat, and the report noted "the airway is widely [open]." A specialist in the disorders of the ear, nose, and throat determined the collection of blood in the throat did not require removal and the patient's airway was safe. The patient received blood transfusions to treat the blood loss.

therapy, the community living center declined to accept the patient because the patient required less than two weeks of skilled nursing care as required for admission.

During the last week of hospitalization, the patient completed the full course of intravenous antibiotics (28 days total) on the medical floor. An occupational therapy provider assessment on hospital day 29 reflected that the patient appeared to be below baseline in ADL function at that time, "primarily limited by diminished activity tolerance and increased [bilateral lower extremity] pain impacting [patient's] ability to perform self-care tasks, mobility, and IADLs." The assessment further noted "Lack of safety equipment in the home, accessibility issues in home, poor safety awareness, fall risk, and limited social supports are also barriers for [patient's] return to previous living environment" and "Minimal to moderate modification or assistance with tasks or assessments is required." On hospital day 30, a physical therapy provider note indicated the patient was "likely to experience difficulties with d/c [discharge] home specifically with ADL/IADLs that require prolonged endurance (cooking, cleaning, dressing) especially in an environment described as a 'shack.'" Both the physical therapy and occupational therapy provider notes reflected that the patient refused discharge to a short-term rehabilitation facility. In addition, the patient reported the inability to tolerate compression and continued to decline dressings on the legs, preferring instead to use pads to catch weeping drainage.

An occupational therapy provider progress note on hospital day 31 stated "Veteran would benefit from STR [short-term rehabilitation] to maximize [patient] function prior to return to previous living environment, however [the patient] is adamantly opposed to this option. For this reason, OT [occupational therapy] recommends HHOT/PT [home health occupational therapy and physical therapy] services to maximize Veteran success with transition back to private residence when medically stable for d/c [discharge]. Consults for specified services (PT [physical therapy] consult for rollator assessment) and DME [durable medical equipment] to be placed." An occupational therapy provider progress note on hospital day 32 recommended "HHOT [home health occupational therapy] for home safety assessment." The social worker documented the patient's short-range plan was to return to their previous [local] living arrangement, with a long-term plan to drive back to Vermont.

The patient was discharged to home in Gainesville after 33 days in the hospital, including time spent in the intensive care unit. The patient lost approximately 33 pounds during the hospitalization. The discharge plan outlined multiple issues for primary care follow-up; specifically, the new diagnosis of acquired factor VIII/ hemophilia A, continued treatment for the leg infection, and recommendations for treatment of the patient's chronic medical problems. A hematologist placed a traveling veteran consult to notify the White River Junction VAMC of the patient's recent hospitalization and to coordinate follow-up care for the patient's acquired factor VIII deficiency/hemophilia A. A note in the medical record stated the patient was "not on AC [anticoagulant] due to history of hematoma and anemia."

Seventeen days after discharge, the patient was admitted to a community hospital with multiple medical problems and subsequently died. The death certificate showed the cause of death was due to septic shock, heart failure, pyelonephritis, and pneumonia.

Inspection Results

1. Adequacy of Discharge Plan

The OIG found that the patient's discharge plan was inadequate to ensure patient safety and continuity of care. The events discussed in this report occurred early in the COVID-19 pandemic and the OIG acknowledges that facilities had to modify the way some services were delivered.[11] However, during one interview the OIG was told that expectations for the quality and comprehensiveness of those services did not change. The OIG determined that IDT communication and coordination deficits, as well as social work-related assessment and discharge planning deficits, contributed to an inferior discharge plan.

IDT Communication and Coordination Deficits

The OIG found that unclear communication expectations and ineffective communication and coordination practices within the Malcom Randall VAMC's IDT negatively affected the quality and comprehensiveness of this patient's discharge plan. The OIG received a memorandum from the White River Junction VAMC that described the IDT as being responsible for initial and ongoing assessment, including daily communication of the patients' continued care needs, and for ensuring that all necessary services and supports are in place prior to discharge.[12] The strength of an IDT lies with the layers of clinical training and expertise across the disciplines, and when communication and coordination are lacking, important input and perspectives on a patient's status and needs may be missed. These gaps could result in a discharge plan that fails to optimize a patient's health, functioning, and safety in the home.

Lack of Written IDT Guidance

VHA does not have an IDT directive or handbook, leaving the form and function of IDTs to local facilities. However, The Joint Commission requires that hospitals coordinate care, treatment, and services based on patients' needs. The Malcom Randall VAMC provided the OIG

[11] World Health Organization, *Naming the coronavirus disease (COVID-19) and the virus that causes it,* accessed August 24, 2021, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(COVID-19-2019)-and-the-virus-that-causes-it; On March 23, 2020, VHA published its *COVID-19 Response Plan, Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan,* which outlined several provisions "to protect healthcare personnel during an infectious disease outbreak/epidemic/pandemic." One such provision was to provide telework options for employees when work could be accomplished via telework.

[12] Facility memorandum 122-17-05, *Discharge Planning Program*, November 14, 2017.

with a list of IDT members who participate in the discharge planning process, which included physicians, nurses, social workers, occupational therapy and physical therapy providers, pharmacists, inpatient care coordinators, utilization management staff, and wound care staff. The Malcom Randall VAMC did not, however, have a discharge planning policy that outlined IDT membership, communication expectations, or roles in discharge planning, and the OIG found that the Malcom Randall VAMC's IDT structure did not consistently include some clinical disciplines to actively participate in IDT rounds. For example, even when physical therapy and occupational therapy providers were heavily involved in a patient's care, they did not participate in IDT meetings, reportedly due to limited staffing to cover overlapping IDT meetings across the facility. In this case, the OIG heard during an interview that physical therapy and occupational therapy providers documented their assessments and recommendations about the patient's abilities and needs in the EHR; however, the relative urgency of these concerns may have been better communicated through the IDT meeting process prior to the patient's discharge.

Inadequate Communication by the Occupational Therapy Provider

The occupational therapy provider did not communicate the change in discharge recommendations regarding safety concerns and the need for a home health occupational therapy safety assessment, nor did the occupational therapy provider take action to stop the discharge. According to a Malcom Randall VAMC memorandum regarding progress notes, the Malcom Randall VAMC's staff, including IDT members, have the option to utilize a communication tool within the EHR titled "additional signer" as well as calling or using instant messaging to alert other disciplines of patient care needs.[13] The occupational therapy provider and occupational therapy supervisor reported that occupational therapy provider notes are documented with the expectation that the IDT will review for status and recommendations. However, reliance on the EHR review as the sole communication method was not effective in this case.

According to a Malcom Randall VAMC policy, if prior to discharge any member of the IDT feels there is any risk concerning the discharge plan, that member will notify the patient's physician that the discharge may need to be canceled. The patient will not be discharged until resolution is made.[14] The occupational therapy provider recommended that home health occupational therapy make a safety assessment but did not ask that the discharge be canceled until that consult was placed and accepted.

The occupational therapy provider did not communicate the change in discharge recommendations made the day before discharge to the physician or any members of the IDT consistent with the facility's established process for communicating pertinent clinical changes. The note, which recommended home health occupational therapy for a home safety assessment,

[13] Malcom Randall VAMC Memorandum No. 136.01, *Progress Notes,* March 11, 2019, change 8 to Appendix C.
[14] Malcom Randall VAMC Memorandum No. 11-17, *Patient Discharge and/or Transfer*, May 30, 2019.

was not signed by the occupational therapy provider until the day of discharge, three hours before the patient was discharged. According to Health Information Management Service, unsigned progress notes are not visible to other team members.

The OIG learned through an interview with the occupational therapy supervisor that the expectation for communication of recommendations or changes to recommendations included use of the additional signer tool, contacting the provider directly by telephone or instant messaging, and then documenting in the EHR. In this case, the OIG found that while the attending physician co-signed the hospital day 29 occupational therapy consult as expected, the occupational therapy provider did not use the additional signer function for notes written on hospital days 30, 31, or 32. Similarly, the physical therapy provider did not use the additional signer function for the hospital day 30 physical therapy provider note. Because physical therapy and occupational therapy providers were not regular participants in IDT meetings, use of the additional signer tool would have enhanced those providers' abilities to ensure that important clinical information was actively communicated to relevant IDT members.

Inadequate Attention to Clinical Notes by the Attending Physician

The OIG found that the medical attending physician failed to ensure that recommendations from the occupational therapy provider for a home health occupational therapy safety assessment and home health occupational therapy and physical therapy were incorporated into the patient's discharge plan.

A resident physician requested an occupational therapy consult for "placement screening and rehabilitation recommendations" regarding the patient. The occupational therapy provider's assessment on the same day indicated the patient was below normal with ADLs and "limited by diminished activity tolerance and increased [leg] pain impacting [the] ability to perform self-care tasks…" The occupational therapy provider recommended discharge to short-term rehabilitation and the note was co-signed by the medical attending physician.

Two days later, the occupational therapy provider noted the patient "demonstrated poor endurance requiring multiple rest breaks during 5-minute duration of [walking]" and continued to present below prior level of function. The patient was adamantly opposed to short-term rehabilitation. Therefore, "For this reason, occupational therapy recommends HHOT/PT [home health occupational therapy and physical therapy] services to maximize [patient's] success with transition back to private residence when medically stable for [discharge]." Just prior to discharge, the occupational therapy provider recommended home health occupational therapy staff conduct a home safety assessment. VHA policy states that all patient care services must be rendered under the supervision of the responsible practitioner or must be personally furnished by

the supervising practitioner.[15] However, neither the medical attending physician nor the resident physician acknowledged reading these notes in the medical record.

The Malcom Randall VAMC's Chief of Medicine acknowledged to the OIG that it may have been an oversight to not order a home health occupational therapy consult. The medical attending physician in this case confirmed to the OIG that occupational therapy recommended consideration of home health therapy because the patient did not want to go to short-term rehabilitation. The home health occupational therapy consult was not ordered prior to the patient's discharge home.

The OIG also found that the medical attending physician failed to ensure that a recommendation from the infectious disease specialist to "Continue wound care and [leg] elevation" was included in the discharge plan. The infectious disease specialists' note indicated that the patient still had "quite a bit of fluid weeping from [the legs] with swelling." The infectious disease specialist ordered four additional weeks of oral antibiotics "while the [leg] edema gets under control." Although the patient refused to allow leg wraps or compression bandages while hospitalized, the patient received intravenous antibiotics and the leg wounds were being monitored by clinical staff. The medical resident ordered the outpatient antibiotics; however, a consult for home health wound care and medication management (administered by skilled nursing) was not in the discharge plan.

The Malcom Randall VAMC's Chief of Medicine told the OIG that "as part of good practice," medical teams are to read the recommendations of subspecialists and try to follow them. The Malcom Randall VAMC Medical Staff Bylaws state that management of the patient's medical condition is the responsibility of a qualified member of the medical staff and that a patient's physician shall follow up on consultation results.[16]

Social Work-Related Discharge Planning Deficits

Social workers have or share significant responsibility for coordinating with IDTs to create a safe discharge plan that supports a patient's treatment goals. The discharge planning process involves evaluating a patient's care needs as they transition from one level of care to another. Discharge planning starts at the time of admission and is conducted throughout the duration of the hospitalization. A comprehensive and timely discharge plan leads to improved outcomes for patients, their families, and caregivers.

The Malcom Randall VAMC's Chief of Social Work told the OIG that most social workers teleworked from early spring through early fall 2020 in accordance with VHA's mission to keep patients, families, and employees safe in the early days of the pandemic when personal protective

[15] VHA Directive 1400.1, *Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents*, November 7, 2019.
[16] Malcom Randall VAMC, *Medical Bylaws & Rules of Veterans Health Administration*, June 4, 2019.

equipment was reserved for direct patient care providers and guidance about COVID-19 safety measures was quickly evolving.[17]

The OIG learned through interviews that the primary social worker in this case was teleworking full-time during the patient's hospitalization and discharge.[18] The social worker reported attending IDT "rounds" daily via telephone, reviewing EHR notes of other care providers to inform the psychosocial assessment and discharge plan, and speaking with the patient over the telephone. However, the social worker acknowledged needing to "rely heavily" on team members who were at the patient's bedside to provide clinical and psychosocial information.[19] The OIG was told during an interview that the social worker did not see the patient in-person during the 33-day admission.

Failure to Conduct Comprehensive Psychosocial Assessments and Follow Up on Clinically Pertinent Information

The OIG determined that social workers did not consistently complete thorough and detailed psychosocial assessments and missed several opportunities throughout the patient's 33-day hospitalization to follow up on clinical information and "red flags" that would be pertinent to discharge planning. Acute care (inpatient) social workers are members of the IDT, completing psychosocial assessments and providing supportive counseling, discharge planning, end of life care, and other services for patients.

The OIG found that while the patient's assigned social workers completed some important elements of a standard psychosocial assessment, they did not consistently ask follow-up questions that would have provided a clearer picture of the patient's potential discharge needs. For example, on the day of admission, the admitting nurse documented that when asked about fears and worries, the response was that the patient was "unable to care for self/lives alone at this time/friend recently died," and placed a consult for social work evaluation. The following day, the assigned social worker noted the patient's Florida address, which the patient described as a

[17] VA National Social Work Program Office, May 6, 2020 "Tip Sheet for Social Workers – Social Work and Telehealth," May 6, 2020. Because of the high demand for VA-issued laptop computers and other devices during the initial stages of the pandemic, social workers were authorized to use their personal computers and mobile devices to conduct their work.

[18] A psychosocial assessment was completed the day after admission by a social work intern, and a discharge planning note on hospital day 15 was completed by a different social worker. The five remaining social work notes leading up to the patient's discharge were completed by a third social worker, referred to as the primary social worker.

[19] VA National Social Work Program Office, May 6, 2020 "Tip Sheet for Social Workers – Social Work and Telehealth," June 23, 2020. Acute care social workers were to limit in-person interactions with patients who were COVID-19 positive as much as possible, using a phone or other approved virtual care method. In the conduct of their work, acute care social workers were responsible for attending rounds or huddles as per the healthcare facility process; reviewing patients' EHRs; and talking to patients' nurses and other team members to learn status, diagnosis, and prognosis, among other relevant information.

"shack," had running water and electricity. The social worker further documented the patient's plan to return to Vermont as soon as the patient could bear weight on the leg. However, the social worker did not document an assessment of the patient's fears or worries related to self-care, mobility, or social supports as referenced in the admitting nurse's assessment, nor did the assessment describe the condition of the "shack;" for example, whether it had a method for providing cooling during warmer conditions, whether it had stairs, or whether it was cluttered. This information would have been useful in determining whether the residence was a suitable environment for discharge after the patient's hospitalization. The psychosocial assessment also did not include information about the patient's living conditions in Vermont.

On hospital days 17, 19, 20, and 23, the assigned social workers' EHR notes reflected an evolving discharge plan that documented the patient's refusal to participate in physical therapy, which rendered the patient ineligible for short-term rehabilitation. Subsequently, the patient's application for nursing home placement while completing intravenous therapy was declined, and the plan was modified to keep the patient on the medical floor until this treatment was finished on hospital day 30.

As noted previously, the occupational therapy and physical therapy providers documented within the last several days of the patient's hospitalization that the patient appeared to be below baseline in ADL function and ability to perform self-care. These assessments completed and documented several days before the patient's discharge provided ample opportunity for the social worker to reassess the patient's status and coordinate a discharge plan providing some level of skilled home health or other support.

Also, the IDT deemed the patient medically stable for discharge on hospital day 30, but the patient "wished to remain in the hospital" for another four days. The EHR did not contain information about, nor could the social worker recall, why the patient wished to stay in the hospital. Understanding the patient's reason for this request may have elicited important data for discharge planning purposes.

Despite the social workers documenting that the patient planned to return to Vermont when able, they did not clarify the patient's intended date to return to Vermont or how the patient planned to get there. This information was vital to determining whether the patient's plan was safe and feasible, as well as the expected time that the patient would still be in Florida and requiring home health or other support services.

According to the social work supervisor, patients can and do overestimate their ability to function independently after discharge; therefore, clinical staff should assess for other measures of functional status beyond the patient's self-report. Without this information, the social worker and other IDT members could not reasonably assume that the patient's discharge plan was adequate or safe.

Failure to Follow Up on Recommendation for a Home Health Occupational Therapy Safety Assessment

The social worker, who had significant responsibility for ensuring the adequacy and safety of the patient's discharge plan, failed to incorporate recommendations by the occupational therapy provider for a home health occupational therapy safety assessment and failed to discuss and offer home health services to manage the venous leg ulcer and monitor the infection of the right leg. Further, the social worker failed to follow up on an email from a member of the facility's Purchased Home Health Care office indicating that the home health agency that provided services after the patient's March 2020 hospitalization requested an order to resume services, if appropriate.[20] The social worker told the OIG that it did not appear anything was done with the information.

The social worker acknowledged during an interview that it was an oversight to not review and follow up on the recommendations for home health occupational therapy from the occupational therapy provider. By contrast, the social work supervisor stated that social work staff are not responsible for following up on the occupational therapy recommendation for home health occupational therapy safety assessments, telling the OIG that it was the physician's responsibility to order skilled home health as the social worker was not able to enter this consult. The social work supervisor said there had been several physical therapy and occupational therapy consults placed, and that the physician "should [have been] reading all of those because things do change after admission." The social work supervisor further stated that had the social worker been informed about the recommendation via an electronic medical alert, instant message, or phone call from the occupational therapy provider, then the social worker would be expected to share that information with the IDT.

While it is true that social workers do not enter home health consults and that the physicians should have been reviewing the physical therapy and occupational therapy provider notes, local Social Work Scope of Practice for Independent Practice Level social workers states that social workers "coordinate discharge planning including information and referral services, [and] identification and access to community resources." Also, according to the facility's Clinical Social Work Service Scope of Service 2020, social workers "continually assess/reassess level of care needs…," which include "recommendations that may be made in conjunction with the interdisciplinary team." Therefore, at a minimum, the social worker had shared responsibility for reviewing and following up on the home health occupational therapy recommendation,

[20] VHA Handbook 1140.6, *Purchased Home Health Care Services Procedures*, July 21, 2006. "Skilled home health care services are in-home services provided by qualified personnel that include: skilled nursing, physical therapy, occupational therapy, speech therapy, social work services, clinical assessment, treatment planning, treatment provision, patient and/or family education, health status monitoring, reassessment, referral, and follow-up. A VA primary care provider prescribes skilled home health care services when medically necessary and appropriate for enrolled veterans."

particularly because there were multiple references to the patient's functional deficits and safety concerns.

In addition, as part of the IDT, social workers use a variety of sources to complete their assessments to include communication with patients, their families, and other members of the IDT, as well as review of patients' EHRs. Further, patients need to be reassessed as their conditions and situations change. The EHR was filled with references to the patient's medical needs (wound care, antibiotics), below baseline functional status (limited mobility and endurance), and lack of social supports. While an electronic computer alert, instant message, or phone call with the physical therapy or occupational therapy providers would have been good practice, it was still the social worker's responsibility to know the patient's needs and plan accordingly for discharge. The social worker acknowledged that the occupational therapy provider notes should have been reviewed, and the social worker should have communicated with the IDT and ensured the consult for home health occupational therapy was entered.

Questionable Application of a Patient's Right to Autonomy

Decision-making capacity is a clinical judgment about a patient's ability to make a particular type of healthcare decision at a particular time. In accordance with the biomedical ethics principle of respect for autonomy, VHA patients have the right to make their own medical decisions and to accept or refuse any medical treatment or procedure recommended to them.[21]

The Malcom Randall VAMC's Chief of Social Work, social work supervisor, and social worker all stated that patients who have capacity have the right to make their own decisions about care and treatment, and that the staff could not make the patient accept services. These are accurate statements and according to VHA policy, the patient's right to autonomy is largely absolute.[22] The OIG determined, however, that none of the patient's statements or intentions—including refusal of physical therapy, desire to be discharged home, or plan to go back to Vermont—obviated the need for adequate and safe discharge planning. Further, refusal of physical therapy did not constitute a blanket refusal of other services. In fact, the patient had received home health services after the March 2020 hospitalization, suggesting that the patient found this to be an acceptable home-care option, at least at that time. Because the home health occupational therapy recommendation was not acted on and other services were not discussed or offered, the patient could not have made the decision to decline them. Given the factors noted above, the OIG found

[21] VHA Directive 1110.04(1), *Integrated Case Management Standards of Practice*, September 6, 2019. While case managers respect patients' "lifestyle choices and behaviors" that may conflict with recommended treatment goals, there are circumstances when case managers "must counsel, strongly advise, and even redirect patients when patient decisions or actions compromise their own safety or the safety of others."

[22] VHA Handbook 1004.01(4), *Informed Consent for Clinical treatments and Procedures*, August 14, 2009 (amended January 4, 2021).

that the patient's right to autonomy, as stated by the social workers, did not provide a defensible justification for inadequate discharge planning in this case.

2. Adequacy of Care Coordination Between Malcom Randall and White River Junction VAMCs

The OIG determined that care coordination between Malcom Randall VAMC and White River Junction VAMC was generally adequate and followed VHA guidelines. Care coordination involves purposefully consolidating patient care activities and distributing information between the members involved with a patient's treatment to achieve safer and more effective care. The primary goal of care coordination is to "meet patients' needs and preferences in the delivery of high-quality, high-value health care."[23] VHA requires facilities to establish processes for patients requesting health care during extended travel from home utilizing a traveling veteran coordinator.[24] Traveling veteran coordinators typically use interfacility consults to communicate patients' needs and document care coordination across VHA facilities. During interviews, the traveling veteran coordinators for Malcom Randall VAMC and White River Junction VAMC described their roles similarly—to coordinate care and services between facilities for traveling veterans.

The OIG found that Malcom Randall VAMC's traveling veteran coordinator initiated a comprehensive interfacility consult on hospital day 30, in preparation for the patient's discharge.[25] In addition, the OIG noted the patient's EHR reflected in three notes, between five and 14 days after discharge, communication between White River Junction VAMC's social worker, family, and patient acknowledging plans to return to Vermont. The communication also included plans for a telephone appointment with the primary care provider at White River Junction VAMC upon return.

Despite finding adequate communication between the facilities' traveling veteran coordinators, the OIG team learned the communication between a Malcom Randall VAMC pharmacist and a White River Junction VAMC pharmacist regarding discontinuation of the patient's apixaban was inadequate. On the day of discharge from the March 2020 hospitalization, a Malcom Randall VAMC pharmacist sent an encrypted email containing the appropriate information to an outpatient pharmacy group email address with "Cancel RX [prescription]" in the subject line. While a White River Junction VAMC pharmacist told the OIG that they were unable to open the

[23] Agency for Healthcare Research and Quality, *Care Coordination* (last reviewed August 2018), accessed May 25, 2021, https://www.ahrq.gov/ncepcr/care/coordination.html.
[24] VHA Handbook 1101.11(3).
[25] The interfacility consult included the reason for referral, specialty consult needed, and prior discharge summary as the current discharge summary was not complete. In lieu of having the current discharge summary, the consult contained current progress notes from the resident assigned to the patient's care including a detailed overview of the patient's status and care needs.

encrypted email, the OIG noted that no apparent effort was made to follow up with the Malcom Randall VAMC pharmacist regarding the content of the email.

The White River Junction VAMC pharmacist who renewed the prescription was unaware the apixaban had been discontinued by Malcom Randall VAMC, and the patient's apixaban was automatically refilled per the 90-day schedule. The White River Junction VAMC did not receive notification that the apixaban had been canceled until acknowledgment of the traveling veteran coordinator consult near the end of the April–May 2020 hospitalization.

After receiving the refill, the patient notified the White River Junction VAMC of the change, signaling the patient's awareness that the medication was discontinued. The White River Junction VAMC pharmacy staff subsequently put a hold on future apixaban refills until hearing back from the patient. While the OIG team did not find evidence that the patient took the anticoagulant, the team notified the White River Junction VAMC's Director and suggested follow-up of this concern.

Conclusion

The Malcom Randall VAMC's IDT team failed to develop a discharge plan that was adequate to ensure patient safety and continuity of care. The Malcom Randall VAMC did not have a discharge planning policy that outlined IDT membership, communication expectations, or roles in discharge planning, and the Malcom Randall VAMC's IDT structure did not consistently support some clinical disciplines, including physical therapy and occupational therapy providers, to actively participate in IDT rounds.

Physical therapy and occupational therapy providers repeatedly assessed the patient's function as below baseline during the 33-day hospitalization. Although the occupational therapy provider documented safety concerns and a change in discharge recommendations reflecting the need for a home health occupational therapy safety assessment, the occupational therapy provider did not communicate this late entry to the physician or any members of the IDT, nor did the occupational therapy provider take action to stop the discharge until those concerns were addressed. The OIG also found that an attending physician failed to ensure that written recommendations from the occupational therapy provider for a home health occupational therapy safety assessment, home health occupational therapy and physical therapy, as well as recommendations from the infectious disease specialist for home wound care, were incorporated into the patient's discharge plan. No home care-related consults were initiated prior to the patient's discharge home.

The OIG determined that social workers did not consistently complete thorough and detailed psychosocial assessments or follow up on clinical information that would be pertinent to discharge planning. For example, the patient's home was self-described as a "shack," but social workers did not ask important questions about the condition of the home such as whether it had a

method of providing cooling during warmer conditions, whether it had stairs, or whether it was cluttered. This information would have been useful in determining whether the residence was a suitable environment for discharge after the patient's hospitalization. Additionally, the social worker did not document the reason the patient wished to stay in the hospital for four days after being medically cleared for discharge or clarify the patient's intended date to return to Vermont or how the patient planned to get there. This information was necessary to determine whether the patient's plan was safe and feasible, as well as the expected time that the patient would still be in Florida and requiring home health or other support services.

The social worker, who had significant responsibility for ensuring the adequacy and safety of the patient's discharge plan, also failed to incorporate recommendations by the occupational therapy provider for the home health occupational therapy safety assessment and failed to discuss and offer home health services to manage the patient's venous leg ulcer and monitor infection of the right leg.

Although the Malcom Randall VAMC's Chief of Social Work, social work supervisor, and social worker all stated or implied that the patient's right to make decisions and decline services was a factor in discharge planning, the OIG determined that none of the patient's statements or intentions—including refusal of physical therapy, desire to be discharged home, or plan to go back to Vermont—obviated the need for adequate and safe discharge planning. Further, refusal of physical therapy did not constitute a blanket refusal of other services.

The care coordination between the Malcom Randall VAMC and the White River Junction VAMC was generally adequate and followed VHA guidelines. The Malcom Randall VAMC's traveling veteran coordinator initiated a comprehensive interfacility consult in preparation for the patient's discharge. However, despite finding adequate communication between the facilities' traveling veteran coordinators, the OIG team determined the communications between a Malcom Randall VAMC pharmacist and a White River Junction pharmacist regarding discontinuation of the patient's apixaban was inadequate. In accordance with established policy, the Malcom Randall VAMC's pharmacist sent an encrypted email containing the appropriate information to an outpatient pharmacy group email address with "Cancel RX [prescription]" in the subject line. While a White River Junction VAMC pharmacist told the OIG that they were unable to open the encrypted email, the OIG noted that no apparent effort was made to follow up with the Malcom Randall VAMC pharmacist regarding the content of the email. While the apixaban was automatically refilled per the 90-day schedule, the OIG team did not find evidence that the patient took the medication. The OIG notified the White River Junction VAMC's Director of this concern.

Recommendations 1–5

1. The Malcom Randall VA Medical Center Director reviews roles and responsibilities for interdisciplinary treatment team members and the process for communication of plans and recommendations from all clinical team members and takes action as indicated.

2. The Malcom Randall VA Medical Center Director ensures clinical staff follow established policy to alert clinical team of pertinent care changes by using the additional signer functionality or other methods of communication.

3. The Malcom Randall VA Medical Center Director conducts a review of care rendered by the assigned occupational therapy provider involved in the discharge planning for the patient and takes follow-up action as indicated.

4. The Malcom Randall VA Medical Center Director conducts a review of care rendered by the attending physician involved in the discharge planning for the patient and takes follow-up action as indicated.

5. The Malcom Randall VA Medical Center Director conducts a review of care rendered by the assigned social worker involved in the discharge planning for the patient and takes follow-up action as indicated.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 27, 2021

From: Director, VA Sunshine Healthcare Network (10N08)

Subj: Healthcare Inspection—Discharge Planning Deficits for a Veteran at the Malcom Randall VA Medical Center in Gainesville, Florida

To: Director, Office of Healthcare Inspections (54RR00)
Director, GAO/OIG Accountability Liaison office (VHA 10BGOAL Action)

1. I have reviewed the VAOIG's report and concur with the findings. Additionally, I have reviewed the Medical Center Director's response and concur with the action plans as submitted.

2. For questions, the VISN 8 Quality Management Officer will act as the point of contact.

(*Original signed by*:)

Miguel H. LaPuz, MD, MBA
Network Director VISN 8

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 22, 2021

From: Director, Malcom Randall VA Medical Center (573)

Subj: Healthcare Inspection—Discharge Planning Deficits for a Veteran at the Malcom Randall VA Medical Center in Gainesville, Florida

To: Director, VA Sunshine Healthcare Network (10N08)

1. I have reviewed the findings within the report. Thank you for helping us move forward on our journey towards high reliability. Appropriate actions have been established with planned completion dates.

2. For questions, please contact the Chief Quality Officer in the Office of High Reliability.

(*Original signed by*:)

David B. Isaacks, FACHE
Executive Health System Director

Facility Director Response

Recommendation 1

The Malcom Randall VA Medical Center Director reviews roles and responsibilities for interdisciplinary treatment team members and the process for communication of plans and recommendations from all clinical team members and takes action as indicated.

Concur.

Target date for completion: Completed

Director Comments

Chief, Medicine Service, conducted a review and updated all standard operating procedures regarding roles and responsibilities for interdisciplinary treatment team members and the process for communication of plans and recommendations from all clinical team members. 100% of interdisciplinary teams and team rounds have been implemented and additional consultants are expected to provide a warm handoff for patients not ready to discharge.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 2

The Malcom Randall VA Medical Center Director ensures clinical staff follow established policy to alert clinical team of pertinent care changes by using the additional signer functionality or other methods of communication.

Concur.

Target date for completion: May 30, 2022

Director Comments

Chief, Medicine Service, conducted a review and updated all standard operating procedures on roles and responsibilities for interdisciplinary treatment team members on process to alert clinical team of pertinent care changes.

Recommendation 3

The Malcom Randall VA Medical Center Director conducts a review of care rendered by the assigned occupational therapy provider involved in the discharge planning for the patient and takes follow-up action as indicated.

Concur.

Target date for completion: January 31, 2022

Director Comments

Chief, Physical Medicine and Rehabilitation Service, conducted a review of care rendered by the assigned occupational therapy provider involved in the discharge planning for the patient. Based on the review, all standard operating procedures regarding documentation standards of therapy notes, will be reviewed and amended as needed. Once amended, all occupational therapy staff will be educated on the amended standard operating procedures as well as the requirement to provide a warm handoff for all patients not ready for discharge. Sustainment chart reviews will be conducted monthly, and additional training/education will be conducted based on the results of the reviews. Any delinquencies found in the chart audit will be forwarded to peer review for follow-up.

Recommendation 4

The Malcom Randall VA Medical Center Director conducts a review of care rendered by the attending physician involved in the discharge planning for the patient and takes follow-up action as indicated.

Concur.

Target date for completion: January 31, 2022

Director Comments

Chief, Medicine Service, will conduct chart reviews monthly to review determine if appropriate discharge planning was completed and appropriate outpatient consults have been placed. Additional training/education will be conducted based on the results of the reviews. Any delinquencies found in the chart audit will be forwarded to peer review for follow-up.

Recommendation 5

The Malcom Randall VA Medical Center Director conducts a review of care rendered by the assigned social worker involved in the discharge planning for the patient and takes follow-up action as indicated.

Concur.

Target date for completion: April 30, 2022

Director Comments

The Chief, Social Work Service, conducted a review of care rendered by the assigned social worker involved in the discharge planning for the patient. Based on the review, all standard operating procedures regarding social worker responsibilities for discharge planning, discharge safety evaluation and communication with interdisciplinary team will be reviewed and amended as needed. Once amended, staff will be educated on the amended standard operating procedures. To ensure sustainment, comprehensive chart reviews will be conducted monthly and additional training/education will be conducted as needed, based on results of the reviews. Any delinquencies found in the chart audit will be forwarded to peer review for follow-up.

Glossary

To go back, press "alt" and "left arrow" keys.

abdomen. The part of the body that contains the stomach, intestine, and other organs.[26]

activities of daily living. Activities to meet a person's basic needs such as grooming, dressing, using the bathroom, walking, and eating.[27]

acquired factor VIII deficiency/hemophilia A. A bleeding disorder that generally occurs in older people where the immune system disables a protein that helps blood to clot.[28]

anemia. A condition in which the blood is deficient in red blood cells, in hemoglobin, or in total volume.[29]

antibiotics. Medicines that prevent the growth of or kill bacteria.[30]

anticoagulation. The process of hindering the clotting of blood.[31]

apixaban. A medicine that is used to help prevent strokes and blood clots in people who have atrial fibrillation.[32]

atrial fibrillation. A rapid, uncoordinated contraction of the heart chambers that results in an irregular heartbeat and pulse.[33]

bacteremia. The presence of bacteria in the blood.[34]

benign prostatic hypertrophy. An enlarged prostate gland that causes uncomfortable urinary symptoms, such as blocking the flow of urine out of the bladder. The terms hypertrophy and

[26] Cambridge English Dictionary, *Abdomen*, accessed May 16, 2021, https://dictionary.cambridge.org/dictionary/english/abdomen.
[27] Peter Edemekong et al., *Activities of Daily Living*, In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing (updated June 26, 2020), accessed on May 17, 2020, https://www.ncbi.nlm.nih.gov/books/NBK470404/.
[28] NIH Genetic and Rare Diseases Information Center, *Acquired hemophilia A*, accessed April 10, 2021, https://rarediseases.info.nih.gov/diseases/6405/acquired-hemophilia-a.
[29] Merriam Webster, *Anemia*, accessed May 15, 2021, https://www.merriam-webster.com/dictionary/anemia.
[30] Microbiology Society, *What Are Antibiotics and How Do They Work?*, accessed May 16, 2021, https://microbiologysociety.org/members-outreach-resources/outreach-resources/antibiotics-unearthed/antibiotics-and-antibiotic-resistance/what-are-antibiotics-and-how-do-they-work.html.
[31] Merriam Webster, *Anticoagulation*, accessed January 25, 2021, https://www.merriam-webster.com/medical/anticoagulation.
[32] U.S. National Library of Medicine MedlinePlus, *Apixaban,* accessed May 14, 2021, https://medlineplus.gov/druginfo/meds/a613032.html.
[33] Merriam Webster, *Atrial Fibrillation*, accessed January 13, 2021, https://www.merriam-webster.com/medical/atrial%20fibrillation.
[34] Merriam Webster, *Bacteremia*, accessed May 16, 2021, https://www.merriam-webster.com/dictionary/bacteremia.

hyperplasia are used interchangeably in the medical literature. The term hypertrophy will be used for the purposes of this report.[35]

cardiology. The study of the heart, its action, and diseases.[36]

cellulitis. A common bacterial skin infection that appears swollen, red, and can be painful when touched.[37]

chronic obstructive pulmonary disease. A common lung disease that makes it hard to breathe.[38]

coronary artery disease. A disease that causes narrowing of blood vessels that supply the heart with blood and oxygen.[39]

deep vein thrombosis. "A condition where a blood clot forms in a deep vein."[40]

diabetes. A disease that occurs when the body cannot effectively process sugar (glucose) due to producing little or no insulin (a hormone that regulates blood glucose) or not using insulin well. Type 2 diabetes is the most common type, patients do not make or use insulin well and may make lifestyle changes, such as diet and exercise, or use oral medications to regulate blood glucose.[41]

diastolic heart failure. "A condition where the left ventricle is not able to properly fill with blood during the diastolic phase [when the heart relaxes and fills with blood], reducing the amount of blood pumped out to the body."[42]

hematology. A branch of medicine that deals with the blood and blood-forming organs.[43]

---

[35] Mayo Clinic, *Benign prostatic hyperplasia (BPH)*, accessed February 7, 2021, https://www.mayoclinic.org/diseases-conditions/benign-prostatic-hyperplasia/symptoms-causes/syc-20370087?p=1.

[36] Merriam Webster, *Cardiology*, accessed May 16, 2021, https://www.merriam-webster.com/dictionary/cardiology.

[37] Mayo Clinic, *Cellulitis*, accessed May 16, 2021, https://www.mayoclinic.org/diseases-conditions/cellulitis/symptoms-causes/syc-20370762.

[38] U.S. National Library of Medicine MedlinePlus, *Chronic obstructive pulmonary disease*, accessed January 13, 2021, https://medlineplus.gov/ency/article/000091.htm.

[39] U.S. National Library of Medicine MedlinePlus, *Coronary heart disease,* accessed January 24, 2021, https://medlineplus.gov/ency/article/007115.htm.

[40] American Heritage Dictionary, *Deep Vein Thrombosis*, accessed May 17, 2021, https://ahdictionary.com/word/search.html?q=deep+vein+thrombosis.

[41] NIH National Institute of Diabetes and Digestive and Kidney Diseases, *Diabetes*, accessed January 13, 2021, https://www.niddk.nih.gov/health-information/diabetes/overview/what-is-diabetes.

[42] Baptist Health, *Diastolic Heart Failure*, accessed June 14, 2021, https://www.baptisthealth.com/services/heart-care/conditions/diastolic-heart-failure.

[43] Merriam Webster, *Hematology*, accessed May 16, 2021, https://www.merriam-webster.com/dictionary/hematology.

hematoma. A mass of clotted blood that forms in a tissue, organ, or body space as a result of a broken blood vessel.[44]

hemoglobin. The part of blood that contains iron, carries oxygen through the body, and gives blood its red color.[45]

hyperlipidemia. Elevated levels of fats in the blood.[46]

infection. "A disease in a part of the body that is caused by bacteria or a virus."[47]

infectious disease specialists. Physicians who treat bacterial, fungal, viral, and parasitic infections.[48]

instrumental ADLs. Activities that allow a person to live independently such as managing finances, preparing food, doing laundry, and cleaning around the house.[49]

intensive care unit. A unit in a hospital providing intensive care for critically ill or injured patients that is staffed by specially trained medical personnel and has equipment that allows for continuous monitoring and life support.[50]

intravenous. "Giving medicines or fluid through a needle or tube inserted into a vein."[51]

lymphedema. Swelling, generally in one of the arms or legs, resulting from blockage in the lymphatic system.[52]

mass. "A lump in the body that may be caused by the abnormal growth of cells, a cyst, hormonal changes, or an immune reaction."[53]

---

[44] Merriam Webster, *Hematoma*, accessed May 13, 2021, https://www.merriam-webster.com/dictionary/hematoma.
[45] Merriam Webster, *Hemoglobin*, accessed May 16, 2021, https://www.merriam-webster.com/dictionary/hemoglobin.
[46] Merriam Webster, *Hyperlipidemia*, accessed January 29, 2021, https://www.merriam-webster.com/dictionary/hyperlipidemia.
[47] Cambridge English Dictionary, *Infection*, accessed May 16, 2021, https://dictionary.cambridge.org/us/dictionary/english/infection.
[48] Mayo Clinic, *Infectious Diseases*, accessed May 16, 2021, https://www.mayoclinic.org/departments-centers/infectious-diseases/sections/overview/ovc-20456906.
[49] Peter Edemekong et al., *Activities of Daily Living*, In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing (updated June 26, 2020), accessed on May 17, 2020, https://www.ncbi.nlm.nih.gov/books/NBK470404/.
[50] Merriam Webster, *Intensive Care Unit*, accessed May 16, 2021, https://www.merriam-webster.com/dictionary/intensive%20care%20unit.
[51] U.S. National Library of Medicine MedlinePlus, *Intravenous*, accessed May 16, 2021, https://medlineplus.gov/ency/article/002383.htm.
[52] Mayo Clinic, *Lymphedema – Symptoms & Causes*, accessed January 13, 2021, https://www.mayoclinic.org/diseases-conditions/lymphedema/symptoms-causes/syc-20374682.
[53] NIH National Cancer Institute, *Mass*, accessed May 17, 2021, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/mass.

methicillin-susceptible staphylococcus aureus. A type of bacterial skin infection that can be treated by the antibiotic methicillin.[54]

mitral valve repair. A surgical procedure where the valve located in the heart that opens to direct blood from the left atrium into the left ventricle requires repair.[55]

obesity. "The condition of having too much body fat."[56]

occupational therapy. Therapy based on engagement in meaningful activities of daily life especially to enable or encourage participation in such activities despite impairments or limitations in physical or mental functioning.[57]

physical therapy. Therapy for the preservation, enhancement, or restoration of physical movement or physical function impaired by disease, injury, or disability.[58]

pneumonia. "An infection in one or both of the lungs."[59]

pyelonephritis. "An infection of one or both kidneys."[60]

rollator. "…A 'wheeled walker." It consists of a frame with three or four large wheels, handlebars, and a built-in seat."[61]

septic shock. A life-threatening severe form of sepsis.[62]

venous stasis. Occurs when blood slows or stops in the vein causing venous stasis ulcers.[63]

---

[54] Association for Professionals in Infection Control and Epidemiology, *Staphylococcus aureus*, accessed September 26, 2021, https://apic.org/monthly_alerts/staphylococcus-aureus/; Centers for Disease Control and Prevention, *Methicillin-resistant Staphylococcus aureus (MRSA) Laboratory Testing*, accessed September 26, 2021, https://www.cdc.gov/mrsa/lab/index.html#anchor_1548429322.

[55] U.S. National Library of Medicine MedlinePlus, *Mitral valve surgery – open*, accessed February 16, 2021, https://medlineplus.gov/ency/article/007412.htm.

[56] U.S. National Library of Medicine MedlinePlus, *Obesity Screening*, accessed February 16, 2021, https://medlineplus.gov/lab-tests/obesity-screening/.

[57] Merriam Webster, *Occupational therapy*, accessed May 16, 2021, https://www.merriam-webster.com/dictionary/occupational%20therapy.

[58] Merriam Webster, *Physical therapy*, accessed May 16, 2021, https://www.merriam-webster.com/dictionary/physical%20therapy.

[59] U.S. National Library of Medicine MedlinePlus, *Pneumonia*, accessed June 7, 2021, https://medlineplus.gov/pneumonia.html.

[60] U.S. National Library of Medicine MedlinePlus, *Urinary tract infection*, accessed May 16, 2021, https://medlineplus.gov/ency/article/000521.htm.

[61] Very Well Health, *How a Rollator Differs From a Walker*, accessed July 1, 2021, https://www.verywellhealth.com/rollator-or-walker-2318324

[62] Merriam-Webster, *Medical definition of septic shock,* accessed on January 13, 2021, https://www.merriam-webster.com/dictionary/septic%20shock#medicalDictionary.

[63] Veindirectory.org, *Everything you need to know about Venous Stasis Ulcers*, accessed July 8, 2021, https://www.veindirectory.org/article/conditions/venous-stasis-ulcers#

wound care. "Wound care involves every stage of wound management which includes diagnosing wound type, considering factors that affect wound healing, and the proper treatments for wound management."[64]

[64] Medilodge, *What is Wound Care and What to Expect During this Treatment*, accessed May 16, 2021, https://medilodge.com/announcement/what-is-wound-care-and-what-to-expect-during-this-treatment/.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Victoria Coates, MSW, MBA, Director Gail Bozzelli, RN Chastity Osborn, DNP, RN Dawn Rubin, JD Glenn Schubert, MPH Laura Snow, LCSW, MHCL Shedale Tindall, RN, MSN Thomas Wong, DO
Other Contributors	Jeanne Martin, PharmD Sarah Mainzer, JD, BSN Natalie Sadow, MBA Robyn Stober, JD, MBA

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Sunshine Healthcare Network (10N08)
Director, New England Health Care System (10N01)
Director, North Florida/South Georgia Veterans Health System (573)
Director, White River Junction VA Medical Center (405)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate
Florida: Marco Rubio, Rick Scott
Georgia: Jon Ossoff, Raphael G. Warnock
New Hampshire: Margaret Wood Hassan, Jeanne Shaheen
Vermont: Patrick J. Leahy, Bernie Sanders
U.S. House of Representatives
Florida: Katherine "Kat" Cammack; Neal Dunn; Al Lawson, Jr.; John Rutherford; Michael Waltz; Daniel Webster
Georgia: Sanford D. Bishop, Jr.; Earl "Buddy" Carter; Austin Scott
New Hampshire: Ann McLane Kuster, Chris Pappas
Vermont: Peter Welch