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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Care Concerns and Failure to Coordinate Community Care for a Patient at the VA Southern Nevada Healthcare System in Las Vegas

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the VA Southern Nevada Healthcare System (facility) in Las Vegas to assess allegations that facility staff delayed ordering medications following a patient's discharge from a community hospital. Additionally, the OIG identified concerns related to the care coordination in community care and primary care, the clinical care provided by a Veterans Integrated Service Network (VISN) physician, and facility staff response to the patient's death by suicide.

Patient Event Summary

The patient, in their eighties, had a past medical history at the facility that included diabetes, high cholesterol, high blood pressure, gastroesophageal reflux disease, chronic gout, and stable chronic kidney disease.[1] In summer 2021 (day 1), the patient was admitted to the community hospital for shortness of breath and abnormal electrocardiogram.[2]

Approximately one week later, using the electronic health record (EHR), a community care nurse alerted the patient's primary care team about the patient's admission. The community care nurse noted that the community care office would continue to monitor the patient's plan of care and coordinate any discharge needs while the patient was hospitalized.

The next day (day 8), the community care nurse entered additional information into the EHR stating the patient had congestive heart failure, was started on Entresto, and was waiting for an external defibrillator vest.[3]

On day 9, the patient telephoned the facility call center and left a message requesting a return call from the primary care nurse, who was electronically alerted to the request. The following day (day 10), the community care nurse documented the patient had been discharged from the community hospital the day prior (day 9).

In the morning on day 11, the primary care nurse returned the patient's call and spoke with the patient and a family member regarding the patient's community hospital discharge follow-up and medication needs. The primary care nurse told the patient's family member to bring the patient's hospital discharge summary to the clinic to have medication orders placed by the provider. The primary care nurse noted in the EHR the patient was diagnosed with congestive heart failure, had

[1] The OIG uses the singular form of they, "their" in this instance, for privacy purposes. The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[2] The patient received care at the Laughlin clinic, which is located 111 miles away from the facility.

[3] Although the community hospital records received on day 7 contained full progress notes from three days (days 3, 5, and 6), the community care nurse entered a Community Care Coordination Plan note on day 8 that only reflected information from the day 6 community hospital provider's progress note.

an external defibrillator vest, and had a VISN clinical resource hub appointment scheduled.[4] The primary care nurse also documented alerting the primary care provider.

Later that morning, the patient and a family member arrived at the clinic for a "walk in" appointment. The primary care nurse reviewed the discharge medication list, noted a cardiology consult was needed, and alerted the primary care provider. Later that day, staff uploaded the community hospital discharge summary report to the EHR, which listed seven new discharge medications and instructions to discontinue one previously prescribed medication.

On day 14, the patient had the clinical resource hub appointment, via telephone, with the VISN physician. The VISN physician documented the community hospital records were not viewable due to technical issues during the patient's appointment. The VISN physician sent a referral to the anticoagulation clinic for apixaban; noted a plan to (however did not) place a community care cardiology consult; ordered follow-up laboratory studies; and refilled the carvedilol (a medication for blood pressure and heart failure). The VISN physician documented the patient declined medications for cholesterol, heart failure, fluid retention, and diabetes.[5] Later, the primary care provider entered a note stating that the patient's community hospital records contained diagnoses of atrial fibrillation, pneumonia, high blood pressure, gout, diabetes, right heart failure, and left-sided heart enlargement consistent with congestive heart failure, and the primary care provider entered a cardiology consult.

The next day, the primary care provider entered a routine prior authorization drug request (PADR) consult for the apixaban for the patient's atrial fibrillation. Two days later (day 17), a VISN PADR program manager pharmacist approved the apixaban for atrial fibrillation and alerted the primary care provider, and the medication was processed by another pharmacist to be sent to the patient by standard mail.

The following day (day 18), a medical support assistant electronically alerted the primary care nurse that a member of the patient's family called the clinic reporting the patient had died the day prior (day 17). Four days later (day 22), the primary care nurse returned the family member's call regarding the patient's death, and documented the family member stated, "I need someone to tell me what to do. [The patient] committed suicide, [the patient] kept waiting to get [the] medications but they never came and [the patient] was depressed." The primary care nurse offered the family member a social work consult, and the family member agreed. About 20 minutes later, the patient's family member spoke with a primary care social worker regarding the patient's death, available support, and the family member's concerns that the patient did not

[4] VA, "Clinical Resource Hubs (CRH)," accessed May 2, 2023, https://www.patientcare.va.gov/primarycare/CRH.asp. Clinical Resource Hubs are "VISN-owned and governed programs that provide support to increase access to [Veterans Health Administration] VHA clinical services for Veterans when local facilities have gaps in care or service capabilities." Care is provided through telehealth or in-person visits and can be used to connect patients with "distant primary care."

[5] The VISN physician did not document the patient's reason for declining the medications.

receive medications. Nine days later, (day 31) a family member spoke to the primary care team regarding disposal of the newly received patient medications.

Deficiencies in Clinical Care Led to Delays in Discharge Medication Approval

The OIG substantiated that deficient clinical care led to a delay in ordering medications following the patient's discharge from a community hospital. The following deficiencies contributed to the patient's delayed discharge medication:

- A community care nurse provided inadequate care coordination.
- Primary care staff failed to provide health education and same-day access.
- A primary care provider failed to order the discharge medications.
- A VISN physician lacked the clinical information necessary to conduct post-discharge care and failed to order the anticoagulant medication.

Community Care Nurse Coordination Failures

The OIG determined that a community care nurse failed to facilitate the delivery of healthcare services, leading to missed opportunities in care coordination during the patient's community hospital stay. The OIG found a lack of communication contributed to the delay in approval and provision of the patient's discharge medications, and other elements of care.

The Veterans Health Administration (VHA) defines care coordination as a "system-wide approach to the deliberate organization of all Veteran care activities between two or more participants or systems to facilitate the appropriate delivery of health care services." "Care coordination also includes appropriate and timely transfer of information, medical documentation, and addressing potential gaps in meeting a Veteran's interrelated clinical and non-clinical needs."[6]

The community care nurse's documentation entry was delayed and omitted information that may have assisted with coordinating the patient's care. Key information that was missing included the patient's primary diagnosis, accurate documentation of the patient's admission status, the need for home oxygen, and a request for the patient's discharge summary documentation. The community care nurse entered the initial community care coordination plan seven days after the patient's admission and failed to provide proactive clinical care coordination in preparation for

[6] VHA Office of Community Care, *Field Guidebook, Chapter 3,* "How to Perform Care Coordination." The Office of Community Care Field Guidebook is a continually updated process and information guide outlining specific functions of community care operations. This specific chapter outlines the care coordination model and specific processes for documenting emergency care in the community, and provides instructions to provide consistency across the VHA enterprise.

discharge. In an interview, the community care nurse manager reported the expectation that the community care nurse's documentation would have contained additional clinical information.

The OIG determined that the delays and omissions limited primary care staff's access to information and impeded the ability to provide care in advance of and after discharge from the community hospital.

Primary Care Staff Care Coordination Failures

The OIG identified that primary care staff care coordination process deficiencies contributed to a delay in the patient receiving prescribed discharge medications.

Per VHA, when a patient transitions between care settings, primary care staff facilitate "safe, effective, and patient-centered transitions," and respond to patients' immediate requests within one business day, or preferably within four hours, based on the patient's clinical need. [7] The OIG found the primary care nurse did not return the patient's phone call made on the date of the discharge (day 9), until two days later (day 11), exceeding the time expectations outlined by VHA.[8]

The OIG determined the primary care nurse's failure to respond timely to the patient's request for a return phone call contributed to a delay in medication as the patient was left without further instruction on how to obtain medication from the VA pharmacy.

The OIG determined that the primary care provider failed to order the patient's discharge medications.

On day 11, while at the Laughlin clinic, the patient's family member provided the primary care nurse with an 18-page patient discharge summary. The primary care nurse also documented the patient needed a cardiology consult and wrote an EHR note which stated, "[the] [patient] should be taking these medications now." Although the primary care nurse communicated the patient's request for discharge medication prescriptions to the primary care provider, the primary care provider did not order the medications. The primary care provider told the OIG of being unable to order the discharge medications because clinical diagnoses were missing from the patient's copy of the discharge paperwork. In a review of EHR documents available to primary care staff on day 11, the OIG found that sufficient clinical information was present in the community hospital documentation to begin the process of ordering the discharge medication. The OIG determined the primary care provider's request to obtain another discharge summary from the community hospital unnecessarily delayed the patient receiving discharge medications.

[7] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 05, 2014, amended on May 26, 2017.

[8] The OIG interviewed the primary care nurse more than a year after the episode of care and the primary care nurse could not remember the patient.

VHA emphasizes the importance of health education, to include how to obtain medication after hospitalization.[9] The OIG learned that the patient initially requested the discharge medications be filled at a local community pharmacy, based on information provided to the patient at an urgent care center.[10] Although community providers are required to send prescriptions to VA pharmacies, patients may choose to fill prescriptions at retail pharmacies at their own expense.[11] The OIG learned in an interview with family members that due to the high cost of the prescriptions, the patient did not obtain the discharge medications after the prescriptions were sent to a community pharmacy and requested the medications be provided by the VA pharmacy.

The OIG determined VHA staff failed to educate the patient and family member about how to obtain the prescribed medications after receiving care at a community hospital. Due to the 111-mile distance between the Laughlin clinic and the VA outpatient pharmacy located at the facility, the OIG expected the patient and family member to receive information from the primary care team on how to obtain prescriptions.[12]

VISN Physician Clinical Care Failures

The OIG determined that a VISN physician lacked clinical information necessary to conduct post-discharge care, did not conduct a complete medication reconciliation, and lacked knowledge of the correct process to order the patient's anticoagulant medication, which contributed to delays in the patient receiving discharge medications.

The VISN physician met with the patient on day 14 for a telephone appointment for the patient to obtain discharge medications. The VISN physician reported being unable to access scanned community health records including the patient's discharge summary due to technical issues. The OIG determined incomplete medication reconciliation and lack of access to key clinical information contributed to an inadequate plan to address the patient's complex medical issues.[13]

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[9] VHA Handbook 1101.10(1).

[10] A family member told the OIG that a non-VA urgent care staff member informed the patient the community pharmacy would accept VA payment for medication.

[11] VHA Reference Sheet, *Veterans Prescription Benefit*, June 7, 2019. Patients can fill urgent/emergent prescriptions written by an authorized community provider for 14 days or fewer at a VA pharmacy or any non-VA pharmacy. VHA will not reimburse the patient for prescription costs if the patient decides to fill and pay for prescriptions through a non-VA pharmacy, unless the prescription was previously approved by VHA, or the prescription is deemed as urgent/emergent by the community provider; "Medication Copayments" (web page), VA Health Benefits, accessed March 28, 2023, https://www.va.gov/healthbenefits/resources/publications/hbco/hbco_copayments.asp. VHA outpatient medication copayment costs are based on a number of factors including, veteran priority group, and medication type and range from no cost, to 5, 8, and 11 dollars for 30-day or less supplies.

[12] The VA outpatient pharmacy is located in the North Las Vegas VA Medical Center, 111 miles from the clinic.

[13] MCM 119-18-24, *Medication Reconciliation*, December 2018. Medication reconciliation is an important aspect of patient care, and all VHA providers are required to discuss medications and any potential harm of medications or therapies with patient.

The OIG found that the VISN physician lacked awareness of the process for ordering the patient's apixaban, and incorrectly entered an anticoagulation consult instead of the required PADR consult. In addition, although urgently needed, the PADR consult and medication orders were entered by the primary care provider as routine, which delayed expedited shipping of the patient's apixaban.[14]

Deficiencies in Facility Staff Response to the Patient's Death by Suicide

After learning of the patient's death by suicide, primary care staff failed to notify suicide prevention staff and failed to complete a suicide behavior overdose report (SBOR) "immediately upon notification of an event."[15] Further, the OIG determined that a former suicide prevention program manager failed to take action such as informing the suicide prevention coordinator to timely complete the behavioral health autopsy (BHA) and a family interview tool contact (FIT-C) form.[16]

During an interview, the OIG learned the primary care nurse was unaware of the need to complete a SBOR to notify suicide prevention staff of the patient's death by suicide and denied receiving training on these topics.[17] Through reviewing training records and facility policies, the OIG learned the primary care nurse received training on the facility management of veterans at

[14] MCM 119-19-18, *Non-Formulary and Prior Authorization Drug Request*, January 2019. Facility policy requires the use of an electronic consult to request a medication that requires a PADR before the medication can be prescribed for a patient and if a patient needs the medication urgently, the provider must document the urgent request in the consult and notify pharmacy staff by telephone.

[15] VHA Directive 1160.07; VA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide," November 1, 2020. VHA requires providers to notify a suicide prevention coordinator when the provider becomes aware of any self-directed violence behavior, including death by suicide. Providers further document the behavior in the EHR through a templated note called a suicide behavior overdose report.

[16] VHA Directive, 1160.07; VA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide," November 1, 2020. Although a facility's suicide prevention team members may include suicide prevention coordinators, suicide prevention case managers, peer support specialists, and other designated staff; the completion of the BHA and FIT-C are the responsibility of the suicide prevention coordinator.

[17] MCM 116-18-03, *Management of Veterans at High Risk for Suicide,* June 2018. This policy was in effect for a portion of the time frame of the events discussed in this report. It was rescinded and replaced by MCM 116-19-03, *Management of Veterans at High Risk for Suicide*, December 2019 and later replaced by MCM-116-21-03, *Management of Veterans at High Risk for Suicide*, January 2021, updated December 2021. The 2021 policy has the same language as the 2018 policy related to suicide prevention training and suicide behavior reporting responsibilities.

high risk for suicide policy in mid-spring 2018, prior to the facility adding the option for nurses to complete an SBOR.[18]

VHA requires a suicide prevention coordinator to complete BHA, and FIT-C forms within 30 days of awareness of a patient's death by suicide.[19] Although suicide prevention staff became aware of the patient's death by suicide in late spring 2022, the OIG found a former suicide prevention program manager failed to take action to initiate the BHA and FIT-C, which were not completed until early winter 2022, a delay of seven months and more than one month after the OIG opened the inspection.

The OIG made one recommendation to the VISN Network Director to review the patient's course of care and take actions as warranted and four recommendations to the Facility Director related to community care coordination, primary care processes, and actions required following a patient death by suicide, and to take actions as warranted.

VA Comments and OIG Response

The Veterans Integrated Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.

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Assistant Inspector General
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[18] MCM 116-15-03, *Management of Veterans at High Risk for Suicide*, April 2015. This policy was in effect at the time the primary care nurse received training relevant to suicide policy. This policy did not identify registered nurses as staff responsible for completing suicide behavior reporting. It was rescinded and replaced by MCM 116-18-03, *Management of Veterans at High Risk for Suicide*, June 2018. The 2018 policy did identify registered nurses as responsible staff, however, was not in effect when the primary care nurse took the training.

[19] VHA Directive, 1160.07; VA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide," November 1, 2020. After the BHA and FIT-C are completed, "statistical staff and program analysts…collect, process, and evaluate the information provided to uncover larger statistical trends and improve VA's [suicide prevention program];" VA, *Behavioral Health Autopsy Program Data Definitions: Description of Elements on the BHAP Chart Review and FIT-C forms*. The BHA is completed through use of an EHR analysis template, which includes "demographic characteristics, risk & protective factors, use of mental health and crisis services, diagnoses and symptoms, and clinical impressions. The FIT-C is a form completed through a conversation with the deceased's family members "to understand the circumstances impacting the Veteran's life in the time before the death."

Contents

Abbreviations

ADPCS	Associate Director of Patient Care Services
EHR	electronic health record
FIT-C	family interview tool contact
OIG	Office of Inspector General
PADR	prior authorization drug request
SBOR	suicide behavior overdose report
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information System Technology Architecture

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the VA Southern Nevada Healthcare System in Las Vegas after receiving an allegation related to a delay in ordering medications following a patient's discharge from a community hospital. Additionally, the OIG identified concerns related to the care coordination in community care and primary care, the clinical care provided by a Veterans Integrated Service Network (VISN) physician, and facility staff response to the patient's death by suicide.

Background

The VA Southern Nevada Healthcare System in Las Vegas, Nevada, is part of VISN 21 and is designated as a level 1b, high complexity system.[1] The North Las Vegas VA Medical Center (facility) has 140 operating hospital beds and provides medical, surgical, and mental health services. The facility has seven outpatient clinics in Nevada: the Northeast, Northwest, Southeast, Southwest, and West Cheyenne clinics in Las Vegas; and clinics in Laughlin and Pahrump.

The Laughlin clinic provides primary care, audiology, and laboratory services. The VA outpatient pharmacy for the clinic is located 111 miles away in the facility. Facility staff members reported to the OIG that a primary care provider provides telehealth services to Laughlin clinic patients with a minimum of four days of face-to-face visits per month. From October 1, 2021, through September 30, 2022, the Laughlin clinic served 2,216 patients.

Allegations and Related Concerns

On January 31, 2022, the OIG received a complaint from a family member (complainant) alleging that facility staff delayed approval of prescription medications following the patient's discharge from a community hospital.[2] The complainant stated that the patient was concerned about the out-of-pocket costs for multiple medications after the discharge medication prescriptions were sent to a community pharmacy to be filled. The complainant further reported that the patient was in pain while waiting to receive the medications from the facility that were

[1] Veterans Health Administration (VHA) Office of Productivity, Efficiency, and Staffing, "Facility Complexity Model Fact Sheet," January 28, 2021. The VHA Facility Complexity Model categorizes medical facilities as levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex. A level 1b facility has "medium-high volume, high risk patients, many complex clinical programs, and medium-large research and teaching programs."

[2] The complaint was originally submitted to the Department of Health and Human Services and then forwarded to the VA OIG.

prescribed at discharge by the community hospital. The patient died by suicide in the summer of 2021.

The OIG contacted facility leaders regarding the complainant's allegation and sent a request for information on April 1, 2022. After reviewing the facility leaders' response, the OIG determined additional information was needed and sent a second request on August 17, 2022. The OIG reviewed facility leaders' responses and determined the responses did not adequately address the allegation.

The OIG initiated a healthcare inspection to review the complainant's allegation that facility staff failed to approve and provide timely discharge medications for the patient and to review facility leaders' responses.

Additionally, the OIG identified concerns related to the coordination of care for the patient, including deficiencies in the facility's community care and primary care, the clinical care provided by a VISN physician, and the facility's suicide prevention program.

Scope and Methodology

The OIG initiated the healthcare inspection on November 16, 2022, and conducted a site visit from January 10 through 12, 2023.

The OIG team interviewed leaders from the facility, as well as facility and VISN 21 staff familiar with the patient's care and relevant processes, a member of the patient's family, and the complainant.[3]

The OIG reviewed the patient's electronic health record (EHR), as well as pertinent Veterans Health Administration (VHA) and facility policies and procedures related to community care, primary care, pharmacy, and suicide prevention.

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).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take

[3] The OIG interviewed a VISN prior authorization drug request program (PADR) manager pharmacist and a VISN physician. Facility leaders interviewed included the Facility Director, Chief of Staff, Associate Director of Patient Care Services, and department chiefs for Quality, Safety and Value, Primary Care, and Community Care; a community care nurse manager; a pharmacy community care program manager, an outpatient pharmacy manager; and a former suicide prevention program manager. Facility staff interviewed included a Laughlin Clinic primary care provider, a primary care registered nurse, a primary care social worker; a community care nurse; a durable medical equipment coordinator; a medical records file clerk; an anticoagulation pharmacist; a suicide prevention coordinator and a suicide prevention case manager.

place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. 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 Event Summary

The patient in their eighties had a past medical history that included diet-controlled diabetes, high blood pressure, diet-controlled high cholesterol, gastroesophageal reflux disease, chronic gout, and stable chronic kidney disease (after resection of one kidney for successful treatment of cancer more than 40 years ago).[4]

In summer 2021 (day 1), the patient was seen in a community urgent care center and subsequently admitted to a community hospital for shortness of breath and abnormal electrocardiogram. Two days after admission (day 3), the patient called the facility call center to schedule a community hospital discharge follow-up appointment. Due to primary care provider appointment unavailability, a medical support assistant noted in the EHR the need to schedule an alternative clinical resource hub appointment.[5] The following day (day 4), a primary care licensed practical nurse left the patient a message on how to schedule a clinical resource hub appointment and alerted the primary care registered nurse (primary care nurse) who acknowledged the alert three days later.

The following week (day 7), a community care nurse (community care nurse) at the facility sent an electronic alert to the patient's primary care team through the EHR about the patient's hospital admission for shortness of breath, pneumonia, and atrial fibrillation. The primary care nurse spoke to the patient the next day (day 8) and provided instruction to call the Laughlin clinic once discharged, and at that time an appointment with the clinical resource hub would be

[4] The OIG uses the singular form of they, "their" in this instance, for privacy purposes. The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[5] VA, "Clinical Resource Hubs (CRH)," accessed May 2, 2023, https://www.patientcare.va.gov/primarycare/CRH.asp. Clinical Resource Hubs are "VISN-owned and-governed programs that provide support to increase access to VHA clinical services for Veterans when local facilities have gaps in care or service capabilities." Care is provided through telehealth or in-person visits and can be used to connect patients with "distant primary care."

made. The community care nurse entered additional information into the EHR stating the patient had congestive heart failure, atrial fibrillation, started on Entresto (sacubitril/valsartan), and was awaiting an external defibrillator vest.[6] One day later (day 9) the patient left a message, as instructed, with the facility call center requesting a return call from the primary care nurse, who was electronically alerted to the request the same day. The following morning (day 10), the community care nurse entered a community care coordination plan addendum note in the EHR documenting the community hospital staff planned for the external defibrillator vest to arrive that evening and discharge planning was proceeding. The community care nurse later added additional information to the EHR note indicating the patient was discharged from the community hospital on day 9.

In the morning on day 11, the primary care nurse returned the patient's call from day 9 and spoke with the patient and family member regarding the patient's community hospital discharge follow-up and medication needs. The primary care nurse told the patient's family member to bring the patient's hospital discharge summary to the clinic to have medications ordered. The primary care nurse noted in the EHR the patient was diagnosed with congestive heart failure, had an external defibrillator vest placed, and had a clinical resource hub appointment scheduled; the primary care nurse then electronically alerted the primary care provider.

During a late morning "walk in" appointment for a medication request, the primary care nurse documented in the EHR that the patient's family member stated the patient was released two days prior from a community hospital with an external defibrillator vest for an abnormal heartbeat and shortness of breath. From the patient's hospital discharge summary, the primary care nurse reviewed the discharge medication list, documented a potassium laboratory value in the EHR note, noted a cardiology consult was ordered for the external defibrillator vest, noted the patient's scheduled clinical resource hub appointment, and electronically alerted the primary care provider. About 10 minutes later, the primary care nurse added information to the EHR note documenting the patient's community hospital discharge summary did not contain a diagnosis of congestive heart failure, the clinic staff requested a full discharge summary, the primary care provider did not order medications, and the patient had a scheduled appointment in three days with the clinical resource hub provider (VISN physician).

That afternoon a medical records file clerk uploaded to the EHR the community hospital "Patient Discharge Summary Report" that included seven new discharge medications of apixaban, carvedilol, sacubitril-valsartan (Entresto), furosemide, azithromycin, atorvastatin, and metformin; and instructions to continue taking allopurinol, and stop taking losartan, which had been discontinued in the hospital on day 5. The report listed medication doses, directions, and date and time of the last dose for each medication. The report identified active patient problems

[6] Although the community hospital records received on day 7 contained full progress notes from three days (days 3, 5 and 6), the community care nurse entered a Community Care Coordination Plan note on day 8 that only reflected information from the day 6 community hospital provider's progress note.

of atrial fibrillation, gout, high blood pressure, and pneumonia in addition to abnormal electrocardiogram and shortness of breath diagnoses.

On day 14, the primary care nurse electronically alerted the VISN physician to the community hospital notes available in the Veterans Health Information System Technology Architecture (VistA) system.[7] That afternoon, the patient met with the VISN physician in a telephone hospital follow-up visit. The VISN physician documented being unable to view the community hospital records and wrote the patient had a new diagnosis of atrial fibrillation with evidence of congestive heart failure. The VISN physician further noted a plan to send a referral to the anticoagulation clinic for apixaban, place a community care cardiology consult, order follow-up laboratory studies, and refill the carvedilol blood pressure medication. The patient and family member were to monitor the patient's blood pressure and pulse at home. The VISN physician's note documented the patient declined medications for cholesterol, heart failure, fluid retention, and diabetes.[8] Later that day, after receiving further community hospital records, the primary care provider entered a note stating the records contained diagnoses of atrial fibrillation, pneumonia, high blood pressure, gout, diabetes, right heart failure, and left-sided heart enlargement consistent with congestive heart failure. The primary care provider also entered a cardiology consult.

The next day (day 15), the primary care provider entered a routine prior authorization drug request (PADR) consult for the apixaban for atrial fibrillation, and an anticoagulation pharmacist completed a summary note of day 9 community hospital laboratory testing results. Two days later (day 17), a VISN PADR program manager pharmacist approved the apixaban and electronically alerted the primary care provider. Another pharmacist processed the apixaban order for mailing the same day.

On day 18, a medical support assistant electronically alerted the primary care nurse that a family member called the clinic reporting the patient had died the day prior. The primary care nurse documented sending a notification email regarding the patient's death.[9] Four days later (day 22), the primary care nurse returned the patient's family member's call regarding the patient's day 17 death. The primary care nurse wrote the family member stated, "I need someone to tell me what to do. [The patient] committed suicide, [the patient] kept waiting to get [the] medications but they never came and [the patient] was depressed." The primary care nurse offered the family member a social work consult, and the family member agreed. About 20 minutes later, the

[7] Veterans Health Information System Technology Architecture (VistA) Imaging system "captures clinical images, scanned documents, motion video and other non-text data and makes them part of the patient's electronic medical record." The VISN physician documented ". . . of note, I am unable to sign into Vista Imaging to view any ER [emergency department] visit records." In an interview, the VISN physician reported being unable to access the community hospital discharge note and relied on the primary care nurse's note from three days prior.

[8] The VISN physician did not document the patient's reason for declining the medications.

[9] Through document reviews and in an interview, the OIG learned the primary care nurse sent the email to a facility death notification mail group.

patient's family member spoke with a primary care social worker regarding the patient's death, available support, and the family member's concerns that the patient did not receive medications, possibly contributing to the patient's medical issues. The primary care social worker offered the family member multiple resource contacts and phone numbers. Nine days later (day 31), a family member spoke to the primary care team regarding disposal of the newly received patient medications.[10]

Inspection Results

1. Deficiencies in Clinical Care Led to Delays in Discharge Medication Approval

The OIG substantiated that deficient clinical care led to a delay in ordering medications following the patient's discharge from a community hospital. The OIG cannot determine if the end result would have been different if the patient received the medications. The OIG reviewed the patient's care and determined the following deficiencies contributed to the patient's delayed discharge medication:

- A community care nurse provided inadequate care coordination.
- Primary care staff failed to provide health education and same-day access.
- A primary care provider failed to order the discharge medications.
- A VISN physician lacked the clinical information necessary to conduct post-discharge care and failed to order the anticoagulant medication.

Community Care Nurse Coordination Failures

The OIG determined that a community care nurse failed to communicate to relevant facility providers leading to missed opportunities in care coordination during the patient's community hospital stay. The OIG found this was a contributing factor to the delay in approval and provision of the patient's discharge medications, and other elements of care upon discharge of the patient.

VHA defines care coordination as a "system-wide approach to the deliberate organization of all Veteran care activities between two or more participants or systems to facilitate the appropriate delivery of health care services." "Care coordination also includes appropriate and timely

[10] A review of the EHR by OIG revealed the carvedilol medication was ordered on day 14, the day of the VISN physician phone appointment, and released for mailing by standard mail on day 17. The apixaban was ordered and approved on day 17 and released for mailing by standard mail on day 18. The patient died by suicide on day 17. On day 25 an outpatient pharmacy manager discontinued these two medications previously sent to the patient, as well as a third medication, losartan, that had been released for mailing by standard mail the day prior (day 24).

transfer of information, medical documentation, and addressing potential gaps in meeting a Veteran's interrelated clinical and non-clinical needs."[11]

Upon a patient's arrival at a community emergency department, community hospital staff enter relevant information into an emergency care authorization tool website accessible by VHA facility community care staff.[12] This initial notification begins the care coordination process and community care staff are required to view the website and take action daily.[13] Upon notification, community care staff complete a community care coordination plan EHR note that includes clinical information such as primary diagnosis, the patient's admission status, and a community hospital point of contact (see figure 1). Community care staff are then expected to identify and electronically alert appropriate facility staff "for ongoing follow up."[14] VHA expects community care staff to enter documentation timely, with the intention to promote discharge planning and care coordination.

[11] VHA Office of Community Care, *Field Guidebook, Chapter 3*, "How to Perform Care Coordination." The Office of Community Care Field Guidebook is a continually updated process and information guide outlining specific functions of community care operations. This specific chapter outlines the care coordination model, specific processes for documenting emergency care in the community, and provides instructions to provide consistency across the VHA enterprise.

[12] VHA Office of Community Care, *Field Guidebook, Chapter 3,* "How to Perform Care Coordination." The Emergency Care Authorization Tool is a nationwide electronic repository of information about veterans who self-present to a community emergency department. Community care staff are charged with regularly monitoring this repository and appropriately coordinating care.

[13] VHA Office of Community Care, *Field Guidebook, Chapter 3*, "How to Perform Care Coordination."

[14] VHA Office of Community Care, *Field Guidebook, Chapter 3, "*How to Perform Care Coordination."

Figure 1. *Community care coordination plan EHR note.*
Source: VHA Office of Community Care, Field Guidebook, Chapter 3, "How to Perform Care Coordination."

The community care nurse informed the OIG that information regarding the patient's hospitalization was made available through the emergency care authorization tool website on day 5.[15] Through review of the EHR, the OIG found that scanned images of faxed documentation sent by the community hospital were uploaded for community care review on day 7. The documentation contained clinical information from the patient's hospitalization status, including hospital admission information, courses of treatment, the patient's need for oxygen upon discharge, and an anticipated discharge date.

On day 7, the community care nurse entered a community care coordination plan note that indicated community care staff would ". . . monitor plan of care and discharge needs during the COMMUNITY [*sic*] hospital inpatient stay." The community care nurse also electronically alerted the primary care provider and the primary care nurse to the note.

The community care nurse reported belief that ". . . [a community care nurse's] role is to follow the care and transcribe the notes [into the EHR] and assist with discharge planning. . . as

[15] VHA Office of Community Care, *Field Guidebook, Chapter 3, "*How to Perform Care Coordination." The emergency care authorization tool is a nationwide electronic repository of information about Veterans who self-present to a community emergency department and is a way to transmit and communicate important information needed for care coordination efforts performed by staff charged with regularly monitoring this repository and appropriately coordinating care.

needed." In an interview, the community care nurse reported assisting in coordinating care for discharge needs identified by the community hospital providers, as well as assisting in obtaining community hospital discharge documentation. When asked by the OIG specifically about community care responsibility for discharge medications, the community care nurse stated, ". . . the [primary care provider] takes over that piece, they reconcile, and [community care] doesn't do any of that. [Community care] will just send the clinicals."[16]

The OIG found that the community care nurse failed to electronically alert any other facility staff to assist in the patient's discharge coordination after the first notification to the primary care provider and the primary care nurse. In an interview with the OIG, the community care nurse reported " . . . that was my mistake that [the community care nurse] did not alert the doctor or case manager . . . but it didn't miss a beat because [the patient] was already in contact with [the] [primary care] provider prior to me jumping in."

Through EHR review, the OIG identified that the community care nurse missed opportunities to document pertinent information related to the patient's community hospital stay, which could have assisted in care coordination. The community care coordination plan note omitted

- documentation of the patient's primary diagnosis;
- identification of a community hospital point of contact;
- an accurate documentation of admission status;
- identification and coordination of the patient's post-discharge care needs, such as a cardiology consult, which was required to approve the use of the patient's post-discharge heart medication;
- the need for home oxygen; and
- a request for the patient's discharge summary documentation.[17]

In an interview, the community care nurse manager reported the expectation that the community care nurse's documentation would have listed the patient's conditions and planned interventions, to include electronically alerting primary care that the patient needed a cardiology consult upon discharge. Additionally, the community care nurse manager identified other missed opportunities in care coordination including

- not entering information timely, including an eight-day delay in entering clinical information;

[16] The community care nurse refers to information received from community hospitals as "clinicals."

[17] The community care nurse documented the admission status as "unknown" after receiving the admission and clinical documentation for the previous three days.

- not entering relevant community hospital information in the EHR, including the patient's primary diagnosis, admission status, and identification of the point of contact for the community hospital; and
- missing information related to important descriptions of treatment relevant to the patient's community hospitalization, including interventions related to pneumonia, courses of antibiotics, and the patient's heart condition.

In an interview with the OIG, the Associate Director of Patient Care Services (ADPCS) reported the expectation for community care staff to "[validate] the reason why the patient is in the hospital, and then what is the game plan for that length of stay."

The OIG determined the community care nurse failed to inform relevant facility staff of clinical updates from the community hospital and missed opportunities to document pertinent information. This omission limited primary care staff's access to information requisite to providing care in advance of and after discharge from the community hospital.

Primary Care Staff Care Coordination Failures

The OIG identified Primary Care Service staff care coordination process deficiencies contributed to a delay in the patient receiving discharge medications. The deficiencies included

- a primary care provider failed to provide same-day access;
- a primary care provider failed to order the discharge medications; and
- primary care staff failed to provide health education.

Primary Care Provider Failed to Provide Same-Day Access

The OIG found that primary care staff failed to coordinate care following the patient's community hospital discharge. The OIG determined that Primary Care Service leaders failed to ensure that the patients assigned to a primary care provider and primary care nurse at the Laughlin clinic had same-day access for face-to-face or telephone encounters. The OIG determined that these issues contributed to the delay in the patient receiving timely discharge medications.

Per VHA, when a patient transitions between care settings, Primary Care Service staff facilitate "safe, effective, and patient-centered transitions."[18] In this transition, VHA expects health care information, including community health records, be obtained and clinically recommended care be coordinated to avoid duplication, poor timing, or missed opportunities.[19] When a patient

[18] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 05, 2014, amended on May 26, 2017.

[19] VHA Handbook 1101.10(1).

contacts primary care staff requesting an immediate response, the most appropriate and capable primary care staff should directly respond to the request within one business day, or preferably within four hours, based on the patient's clinical need.[20]

The OIG found that beginning on day 3, while still admitted to the community hospital, the patient and family member attempted to proactively coordinate discharge needs with facility primary care staff by calling the facility to request a follow-up appointment. Scheduling staff documented in the EHR that the patient's primary care provider did not have an available appointment sooner than three weeks and that an appointment would need to be made with the VISN clinical resource hub.[21] The primary care nurse and provider later explained in interviews that scheduled appointments with the clinical resource hub are coordinated through primary care nursing staff. Facility clinical staff and leaders also told the OIG that the clinical resource hub is used for unscheduled and same day patient requests such as discharge follow-up appointments and medications.

The OIG found the primary care nurse called the patient on day 8 and gave the patient scheduling instructions. The primary care nurse documented that the patient and family member have the clinic telephone number, will notify staff when patient is discharged, patient's medical records could be requested, and a follow-up appointment could be scheduled.

On day 9, the patient called the Laughlin clinic and spoke with a medical support assistant. The patient requested to speak with the primary care nurse to provide an update on the community hospital stay and subsequent discharge. Although primary care staff are expected to return patient phone calls within one business day, preferably within four hours, the primary care nurse did not return the patient's phone call until two days later, on day 11.[22]

The patient was discharged from the community hospital on day 9 with seven new discharge prescriptions, including apixaban, atorvastatin, azithromycin, carvedilol, Entresto, furosemide, and metformin. During an interview, the patient's family member reported that the patient requested the community hospital staff send the discharge medications to a local retail pharmacy to be filled believing that VA would cover the cost of the medications.

Per VHA, community providers are required to send prescriptions to VA pharmacies where the prescriptions are filled at little to no cost to the patient; however, patients may choose to fill

[20] VHA Handbook 1101.10(1).

[21] VA, "Clinical Resource Hubs (CRH)."

[22] The OIG interviewed the primary care nurse more than a year after the episode of care and the primary care nurse could not remember the patient.

prescriptions at retail pharmacies at their own expense.[23] The OIG learned in an interview with the patient's family member that because of the cost of the prescriptions at the retail pharmacy, the patient decided to request the medications from the VA pharmacy.

While the patient initially elected to fill the discharge medications at a retail pharmacy without understanding the associated costs, the OIG determined that the primary care nurse failed to respond timely to the patient's request for a return phone call, exceeding the recommended time expectations outlined by VHA. The OIG determined that the primary care nurse's failure to respond timely to the patient's phone call contributed to the delay in medication, leaving the patient without clinical guidance, or further instructions on how to obtain the medication from the VA pharmacy.

The OIG determined that a primary care provider failed to provide the patient same-day access on day 11 to address the patient's needs and coordinate care. According to VHA policy, a patient's request for care "is evaluated promptly" by the primary care staff member who has the "appropriate competency." VHA policy describes "excellent access" and the availability of primary care staff to provide "appropriate clinical advice or care using appropriate modalities of health care delivery at the time patients want and need the advice or care," as a "cornerstone of patient-centered care." Further VHA policy emphasizes, "all [primary care providers and nurses] must ensure they have same-day access . . . for face-to-face encounters, [and] telephone encounters," and that care rendered must be "respectful of the patient's preferences."[24]

On day 11, the patient and a family member spoke with the primary care nurse and requested assistance with obtaining the community hospital prescribed discharge medications. The primary care nurse instructed the patient and family member to bring the discharge summary to the clinic "for triage to order medications." Later that same morning, the patient and family member presented to the Laughlin clinic as instructed.

During an interview, the patient's family member told the OIG that the patient remained in the car downstairs and was unable to walk up the stairs to the second-floor clinic. The OIG learned through document reviews that the elevator to the second-floor clinic was non-functional for patient use and an Issue Brief had been submitted over three months earlier notifying VISN

[23] VHA Reference Sheet, *Veterans Prescription Benefit*, June 7, 2019. Patients can fill urgent/emergent prescriptions written by an authorized community provider for 14 days or fewer at a VA pharmacy or any non-VA pharmacy. VHA will not reimburse the patient for prescription costs if the patient decides to fill and pay for prescriptions through a non-VA pharmacy, unless the prescriptions were previously approved by VHA, or the prescriptions are deemed as urgent/emergent by the community provider. "Medication Copayments" (web page), VA Health Benefits, accessed March 28, 2023, https://www.va.gov/healthbenefits/resources/publications/hbco/hbco_copayments.asp. VHA outpatient medication copayment costs are based on a number of factors including, veteran priority group and medication type, and range from no cost, to 5, 8, and 11 dollars for supplies of 30-days or less.

[24] VHA Handbook 1101.10(1).

leaders of the curtailment of elevator use. [25] Through review of patient safety documents, OIG confirmed the elevator was still inoperable on the day the patient attempted to visit the clinic on day 11. The patient's family member told the OIG that clinic staff previously provided instructions to avoid using the elevator due to its frequent unreliability. Reportedly, the patient's family member requested the primary care nurse to go out to the car and "talk" to the patient, but the primary care nurse refused.

During an interview with the OIG, the primary care nurse could not recall whether the patient was present in the clinic or downstairs in the car. The primary care nurse could not recall if the elevator was functioning on day 11, however, did recall problems with the elevator service in general. The ADPCS told the OIG that the primary care nurse would have been expected to see the patient in the car as the patient's family member reportedly requested. The ADPCS described a contingency plan if a patient is unable to navigate the stairs and the elevator is not functional. Under such circumstances, there is a device that can be utilized to carry patients into the clinic through the stairwell. The Facility Director further reported being unaware that the patient waited in the car and did not attend the visit with the primary care nurse and, like the ADPCS, expected the nurse to see the patient in the car.

The primary care nurse also reported to the OIG that due to unavailability of same-day access appointments with the patient's primary care provider, the primary care nurse sent an electronic message to the clinical resource hub requesting staff schedule the patient for the next available appointment, which was at the beginning of the following week.

When questioned by the OIG regarding lack of same-day access, the primary care provider stated, "I'm booked for six months, I don't have any availability to have an appointment with the patients." The chief of primary care told the OIG that as of early spring 2023, the primary care provider had a four-month wait time for face-to-face appointments, and had next month availability for telehealth appointments. The chief of primary care also said sooner telephone appointments through Primary Care Service were available. Additionally, the chief of primary care noted that other providers may be available, including a provider-of-the-day based in the Southeast clinic, the supervisor of the clinic, and "if all else fails, you can come to me as the chief of primary care." According to the chief of primary care, staff were informed of who to contact when same-day access is needed; verbally, and in writing.

The OIG concluded that the primary care team did not provide same-day access to address the patient's needs and coordinate care for the patient.

[25] Deputy Secretary for Health for Operations and Management (10N) Guide to VHA Issue Briefs, March 29, 2018. "Issue Briefs are drafted to provide specific information to leadership within the organization, working through the appropriate chain of command, regarding a situation/event/issue. Issue Briefs are designed to provide clear, concise, and factual information about unusual incidents, deaths, disasters, or anything else that might generate media interest or impact care." Issue briefs are reviewed by "senior leaders within [VA]– up to the Secretary."

Primary Care Provider Failed to Order the Discharge Medications

The OIG determined the primary care provider failed to order the patient's discharge medications on day 11, when requested by the patient's family member.

Some medications require a PADR, a process that requires additional review and approval of the drug.[26] The adjudication or approval process is completed at the national, VISN, or facility level, depending on the drug.

According to an interview with family members, although the patient was unable to access the Laughlin clinic on day 11, a family member presented to the clinic, met with the primary care nurse, and as confirmed by the primary care nurse, provided an 18-page patient discharge summary as instructed. The primary care nurse reported sending the discharge summary to administrative staff for scanning into the EHR. The primary care nurse also documented that the patient needed a cardiology consult and advised the "[patient] should be taking these medications now." The OIG also learned in the interview that the primary care nurse communicated to the primary care provider the patient's request for discharge medication prescriptions.

The OIG reviewed the patient's EHR and found that the primary care provider did not order the patient's discharge medications, including an antibiotic, blood pressure medication, diuretic, gout medication, diabetes medication, or cholesterol medication. During an interview, the primary care provider told the OIG of being unable to order the discharge medications due to missing clinical diagnoses on the patient's copy of the discharge summary. The primary care provider instructed the primary care nurse to request an alternate discharge summary from the community hospital. Furthermore, the primary care provider told the OIG that discharge summaries are often not available or timely and reported issues accessing scanned medical records in VistA and the Joint Legacy Viewer due to internet connectivity issues.[27]

The OIG reviewed the discharge summary provided by the patient's family member and found that it included the relevant diagnoses and clinical information needed to order the patient's discharge medications including

- discharge medications with dosages, routes, and frequency of use,[28]
- diagnosis of atrial fibrillation, pneumonia,
- laboratory results including creatinine and potassium, and

[26] VHA Directive 1108.08(1), *VHA Formulary Management Process,* November 2, 2016, amended August 29, 2019. It was rescinded and replaced by VHA Directive 1108.08, *VHA Formulary Management Process*, July 29, 2022. Both contain requirements for review and approval of PADRs.

[27] Joint Legacy Viewer (JLV) is an electronic health record that allows providers to see the patient's complete medical history.

[28] According to the primary care provider, Entresto, prescribed to treat congestive heart failure, can only be ordered by Cardiology Service.

- names of the patient care team.

The OIG determined that the discharge summary was scanned and available in the EHR on the afternoon of day 11 and found the primary care provider's request to obtain another discharge summary from the community hospital unnecessarily delayed the patient's discharge medications.

Primary Care Staff Failed to Provide Health Education

In VHA, an important aspect of health education is teaching patients how to access and appropriately utilize health care resources and how to develop self-management skills.[29] This education "spans the continuum of care from the skills and information needed to promote health and prevent disease, to the patient education needed to cope with and manage acute and chronic conditions."[30] One such skill is how to obtain medications after a hospitalization.

In an interview with the OIG team, family members reported that when preparing the patient for discharge from the community hospital, a community hospital physician asked the patient what community pharmacy would be managing the patient's discharge medications. The patient provided the name of a local community pharmacy, based on information provided to the patient at the urgent care center.[31] Family members also explained that due to the high cost of the prescriptions, the patient did not obtain the discharge medications from the community pharmacy.

The ADPCS reported the patient and family member should have received education on how to obtain medication. When reviewing the patient's EHR, the OIG did not find documentation from the primary care team regarding how to obtain medication when receiving care from a community facility.

The OIG concluded the patient and family member did not receive education from VHA staff regarding how to obtain the prescribed medications after receiving care at a community hospital. Due to the 111-mile distance between the Laughlin clinic and the VA outpatient pharmacy located at the facility, the OIG expected the patient and family member to receive information on how to obtain prescriptions to prevent delays in care from the primary care team.

VISN Physician Clinical Care Failures

The OIG reviewed the patient's care and determined that a VISN physician lacked clinical information necessary to provide appropriate post-discharge care, did not conduct a complete

[29] VHA Handbook 1101.10(1).

[30] VHA Handbook 1101.10(1).

[31] A family member told the OIG that a non-VA urgent care staff member told the patient the community pharmacy would accept VA payment for medication.

medication reconciliation, and failed to order the patient's anticoagulant medication, which contributed to delays in receipt of the patient's discharge medications.

VISN Physician Lacked Clinical Information Necessary to Provide Appropriate Post-Discharge Care

VHA policy requires providers to complete medication reconciliation to diminish the potential safety risk for patients and document a plan to address medication discrepancies or problems, such as allergies or adverse drug reactions, difficulties with access to health care, financial hardships, or other related factors that could affect medication adherence.[32] The reconciled list of medications, along with any changes, is communicated to the patient and caregiver.[33] While patients have the right to decline recommended medication treatment plans, VHA providers are responsible for documenting a plan to address medication discrepancies, and the risk of patient harm.[34]

On day 14, the VISN physician met with the patient for a post-discharge "urgent care phone appointment" and documented the purpose of the appointment was for "Medication needs . . . requested of [primary care]. . . not done on [day 11] when requested. [I]nstead a phone [appointment] was made with me." The OIG reviewed the EHR and found the VISN physician documented a copied portion of the primary care nurse's note from day 11, which listed the medications prescribed for the patient upon discharge from the community hospital and identified what medication was discontinued. The VISN physician documented the patient's blood pressure "is quite low, so [the patient] stopped Losartan," refuses "[blood pressure] med[ication]s (ie Entresto), or Diuretics/[potassium]" but no vital signs were completed during visit. The OIG determined the losartan was discontinued on day 5 of the community hospitalization. The VISN physician documented that the patient's medication list was reviewed with the patient; discrepancies addressed; medications orders were updated; the patient had an accurate list of medications, as well as medication education, and counseling was provided to the patient and caregiver; and they verbalized understanding and agreement of the plan of care. Although the VISN physician documented that the steps of medication reconciliation were completed, the OIG found, as detailed throughout this section, multiple failures in the VISN physician's medication reconciliation process.

The OIG reviewed the EHR and found the primary care nurse's documentation included a list of newly prescribed and discontinued medications but was missing information from the discharge

[32] VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011. It was rescinded and replaced by VHA Directive 1345, *Medication Reconciliation*, March 9, 2022. Both directives contain the same language as it relates to VA provider responsibilities.

[33] VHA Directive 2011-012. It was rescinded and replaced by VHA Directive 1345, *Medication Reconciliation*, March 9, 2022. Both directives contain the same language as it relates to communication with patients and caregivers.

[34] Medical Center Memorandum 119-18-24, *Medication Reconciliation*, December 2018.

summary, including diagnoses, full laboratory results, vital signs, and other clinical details.[35] The OIG reviewed the VISN physician's EHR documentation and compared it to the nine discharge medications listed in the primary care nurse's documentation, and in the patient discharge summary.[36] The OIG found the VISN physician ordered the patient's carvedilol and copied nursing documentation, from the visit three days earlier, that the patient refused atorvastatin and did not include evidence that the refusal was discussed with the patient. The VISN physician updated previously prescribed medications and indicated the patient should stop taking losartan and should continue taking allopurinol. The OIG found the VISN physician

- failed to document the patient's reasons for refusing Entresto, furosemide, and metformin;
- did not provide the patient with azithromycin or document why the medication was not ordered; and
- failed to discontinue losartan (see table 1).

Table 1. VISN Physician Discharge Medication Reconciliation

Discharge Medication	VISN Physician EHR Documentation	OIG Analysis of VISN Physician Medication Ordering Actions
Allopurinol	"CONTINUE TAKING"	Allopurinol was prescribed prior to the patient's hospitalization and no action was needed to continue.
Apixaban	"Will send referral for [anticoagulation] Clinic for [Apixaban]."	The VISN physician entered an anticoagulation pharmacy consult that was discontinued by the service.
Atorvastatin	"[The patient] refuses Statin . . .**of note, I am unable to sign into Vista Imaging to view any [Emergency Room] visit records**"†	The medication was not ordered, the reason for the patient's refusal was documented from the primary care nurse's documentation.
Azithromycin	None	The medication was not ordered, and the VISN physician documented no action or reason.
Carvedilol	"will send Carvedilol at low doses."	The medication was ordered.

[35] The primary care nurse's documentation included a single laboratory value for potassium.

[36] Of the total nine medications, the patient had been previously prescribed two medications and seven new discharge medications.

Discharge Medication	VISN Physician EHR Documentation	OIG Analysis of VISN Physician Medication Ordering Actions
Entresto	"[The patient] refuses…[blood pressure] meds (ie Entresto) . . .**of note, I am unable to sign into Vista Imaging to view any ER [emergency department] visit records**"†	This medication was not ordered, and the reason for the patient's refusal not documented.
Furosemide	"[The patient] refuses . . . Diuretics/[potassium] **of note, I am unable to sign into Vista Imaging to view any ER [emergency department] visit records**"†	This medication was not ordered, and the reason for the patient's refusal not documented.
Losartan	"[blood pressure] is quite low, so [the patient] stopped Losartan for now & will monitor [blood pressure]."	The medication was not discontinued and was mailed to the patient.*
Metformin	"Patient did not want to take meds for [diabetes] (so I'll hold Metformin as well)"	This medication was not ordered, and the reason for the patient's refusal not documented.

Source: OIG analysis of EHR records.
** Losartan was prescribed prior to the patient's hospitalization and was discontinued while the patient was hospitalized.*
*†Statements containing ** are quoted verbatim from the EHR.*

During an interview, the VISN physician reported being unable to access scanned community health records, including the patient discharge summary, due to technical issues during the patient's appointment and relying on the primary care nurse's day 11 EHR note. The OIG determined the VISN physician lacked access to key clinical information about the patient's hospitalization, which precluded the ability to conduct a complete medication reconciliation.

The VISN physician told the OIG that because the patient refused to take other medications prescribed after the community hospitalization, the focus of the visit was on obtaining the apixaban. The OIG would have expected the VISN physician to evaluate the patient's reason for declining medications, explain the rationale and action of the medication to treat the patient's symptoms and condition, potential benefits or alterative treatment, and potential risks if not addressed. The OIG would have expected this assessment, evaluation, and education provided to the patient and family member to be documented in the patient's EHR, as well as a return to clinic recommendation for the patient to be seen by their primary care provider. The OIG determined incomplete medication reconciliation and lack of access to key clinical information contributed to the lack of an adequate plan to address the patient's complex medical issues.

VISN Physician Failed to Order the Anticoagulant Medication

Facility policy requires the use of an electronic consult to request a medication that requires a

PADR before the medication can be prescribed for a patient.[37] This PADR consult is expected to be "reviewed and completed by Pharmacy Service within 96 hours for outpatient requests" unless the provider determines that the medication is needed urgently. If the patient needs the medication urgently, the provider must document the urgent request in the consult and notify pharmacy staff by telephone.[38] Patients and staff can also notify the facility's Pharmacy Service line of the urgently needed medication.

During the day 14 telephone encounter with the patient and family member, the VISN physician reviewed the medications requested and transcribed the primary care nurse's documentation that the patient was discharged with an external defibrillator vest, the presence of an abnormal electrocardiogram, and the patient's diagnosis of shortness of breath. The VISN physician documented entering an anticoagulation clinic consult for the apixaban and a consult for community care cardiology. The OIG reviewed the EHR and found the VISN physician

- did not enter a return to clinic order for a follow-up appointment with the patient's primary care provider;
- entered the anticoagulation clinic consult instead of entering a PADR consult for the apixaban; and
- failed to enter the community care cardiology consult order.

Due to the patient's high risk for complications and morbidity, the OIG would have expected a timely return to clinic order to ensure an integrated, comprehensive care management and coordination plan for this medically complex patient.

The VISN physician told the OIG that an anticoagulation consult was needed due to the patient's apixaban prescription, which the VISN physician said, "usually goes to Anticoag[ulation] clinic in most places" and the community care cardiology consult to "keep going with [their] treatment."[39] The OIG found the VISN physician failed to adhere to facility policy and did not enter a PADR consult or order the anticoagulant medication.[40]

The OIG reviewed the PADR consult and medication order for the apixaban later entered by the primary care provider and found the time frame for processing was entered as routine. The anticoagulation pharmacist discontinued the anticoagulation clinic consult and changed the

[37] MCM 119-19-18, Non-Formulary and Prior Authorization Drug Request, January 2019.

[38] MCM 119-19-18.

[39] An anticoagulation clinic consult was incorrectly ordered to obtain the apixaban; a PADR consult was required. A cardiology consult was required due to Entresto's restriction to cardiology service.

[40] MCM 119-19-18.

PADR consult to expedited.[41] The PADR consult was completed on day 17. The primary care provider entered the apixaban order on the same day but did not request to expedite the delivery of the medication. According to the EHR, the medication was sent by the facility through routine mail and the patient's family reported receiving it after the patient's death. The patient's last dose of apixaban was on day 8. The OIG was told by multiple facility staff and leaders that the 14-day time span between the last dose of apixaban and when the medication was received was a significant delay.

The OIG determined the VISN physician lacked awareness of the process for ordering anticoagulant medication and the required use of the PADR, which delayed expedited shipping of the patient's apixaban.

On February 14, 2023, the OIG elevated the following patient safety concerns to the VISN Chief Medical Officer including

- lack of VISN physician knowledge regarding the VISN PADR process when ordering anticoagulants;
- lack of VISN physician knowledge regarding how to expediate the VISN PADR process and delivery of anticoagulants; and
- providers' report of difficulties accessing scanned EHRs.

Later that same day, the VISN Chief Medical Officer provided the OIG with a corrective action plan to address the knowledge gaps regarding the VISN PADR process and how to expedite delivery of anticoagulants, and the inability to access scanned documents in the EHR. The OIG requested updates of the VISN's action plan on April 6, 2023, and July 17, 2023, and received a summary of actions completed in March and May, 2023: The VISN Quality Management Officer reported

- Clinical Resource Hub providers received a fact sheet identifying the correct process for "providing medications to Veterans across the VISN;"
- prescribing practitioners received education about expediting the VISN PADR process;
- instructions for obtaining records through the EHR were disseminated VISN wide; and

[41] When the anticoagulation pharmacist canceled the anticoagulation clinic consult due to the apixaban order, the VISN physician added the comment that the patient was not receiving an anticoagulant and the processing time for the consult was expedited.

- an interim clinical resource hub primary care chief provided the VISN physician with re-education and follow-up, regarding "how to access scanned documents and how to access appropriate care and discharge documents."

Additionally, the VISN Quality Management Officer reported that specific education regarding the VISN PADR process was presented and recorded in May 2023 for all primary care, surgery, and specialty providers in VISN 21.

2. Deficiencies in Facility Staff Response to the Patient's Death by Suicide

The OIG determined primary care staff failed to notify suicide prevention staff of the patient's death by suicide and failed to complete a suicide behavior overdose report (SBOR) "immediately upon notification of an event." The OIG found that while the facility suicide prevention staff provided training to clinical staff regarding actions to take following notification of a patient's death by suicide, the primary care provider and primary care nurse denied receiving any trainings or knowledge regarding required actions. The OIG determined a former suicide prevention program manager did not take actions when first notified of the patient's death by suicide, leading to a delay in completing reporting actions, including completion of a behavioral health autopsy (BHA) and a family interview tool contact (FIT-C) form, as required by VHA.

Failure to Complete Suicide Behavior Overdose Report Within Required Time Frame

VHA requires providers to notify a suicide prevention coordinator when the provider becomes aware of any self-directed violence behavior, including death by suicide.[42] Providers further document the behavior in the EHR through a templated note called an SBOR "immediately upon notification of an event."[43] VA identifies staff who should complete the SBOR, including physicians, psychologists, nurse practitioners, registered nurses, and licensed clinical social workers.[44]

VHA requires suicide prevention coordinators to educate VA providers on how to report suicidal behaviors, including instructions on how to complete an SBOR.[45] In April 2015, the facility policy on management of veterans at high risk for suicide, identified that suicide prevention coordinators were responsible for educating physicians, psychologists, dentists, physician assistants, nurse practitioners, and licensed clinical social workers on how to complete a suicide

[42] VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021.

[43] VHA Directive 1160.07; VA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide," November 1, 2020.

[44] VA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide."

[45] VHA Directive 1160.07.

behavior report.[46] In June 2018, the updated policy required suicide prevention coordinators to include registered nurses in the training provided.[47]

According to the EHR, in summer 2021, the patient's family member informed the primary care nurse of the patient's death by suicide, during a telephone call. The primary care nurse then documented the patient's cause of death in an EHR note and electronically alerted the patient's primary care provider, who acknowledged receipt the same day. The primary care nurse also entered a consult for social work to contact the patient's family member who "need[ed] to know what to do next" regarding death benefits.

The OIG found no evidence in the EHR that primary care staff notified suicide prevention staff or completed the SBOR.

In interviews, suicide prevention staff reported first becoming aware of the patient's death by suicide in late spring 2022, almost 10 months after primary care staff were initially notified. Suicide prevention staff reported completing the SBOR in the EHR upon notification, however, recognized completion was delayed due to primary care staff's failure to notify suicide prevention staff of the patient's death by suicide.[48] One of the suicide prevention staff interviewed further reported the delay "put [suicide prevention] in a position where [they] weren't able to reach out to the family initially and give them information that would have been helpful . . .[the family] had their funeral services . . .at that point it was just [suicide prevention] . . . plugging in information."

During an interview, the primary care nurse reported

- being unaware of the need to complete an SBOR, as a registered nurse;
- no knowledge that suicide prevention staff were to be notified of the patient's death by suicide; and
- not receiving training on how to complete an SBOR.[49]

The OIG requested a list of training from the primary care nurse's supervisor and conducted a

[46] MCM 116-15-03, *Management of Veterans at High Risk for Suicide*, April 2015. This policy was in effect during the time frame that the primary care nurse took training on this policy, as discussed in this report.

[47] MCM 116-18-03, *Management of Veterans at High Risk for Suicide*, June 2018. This policy was in effect during the time frame that the primary care provider took training on this policy, as discussed in this report. It was rescinded and replaced by MCM 116-19-03, *Management of Veterans at High Risk for Suicide*, December 2019 and later replaced by MCM 116-21-03, *Management of Veterans at High Risk for Suicide*, January 2021, updated December 2021. The 2021 policy has the same language as the 2018 policy related to suicide prevention training and suicide behavior reporting responsibilities.

[48] VHA Directive 1160.07; VA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide."

[49] VHA Directive 1160.07; VA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide."

review of courses. Through reviewing training records and facility policies, the OIG learned the primary care nurse received training on the facility management of veterans at high risk for suicide policy in mid-spring 2018, prior to the facility adding the option for nurses to complete an SBOR.[50] When asked how often suicide prevention staff provides primary care staff with training on actions following a patient's death by suicide, the primary care nurse's supervisor stated, "we do not have any training post suicide."

During interviews the primary care provider reported

- belief that the primary care nurse used the electronic alert only to notify the primary care provider the patient's cause of death, and reported taking no additional actions as a result;
- no knowledge of previously caring for other patients who died by suicide, however, would "probably [have] contact[ed] mental health" if the primary care provider needed to take action; and
- no knowledge of ever being informed to complete an SBOR.[51]

Through document review, the OIG learned the primary care provider completed training on the facility's suicide prevention policy and procedure training in mid-fall 2018. However, in an interview the primary care provider denied receiving training on the topic.[52]

Through EHR reviews, the OIG learned approximately 20 minutes elapsed between the time the primary care nurse documented the patient's reported cause of death in the EHR note, and the time the primary care social worker contacted the patient's family member in response to the consult. During an interview, the primary care social worker

[50] MCM 116-15-03, *Management of Veterans at High Risk for Suicide*, April 2015. This policy was in effect at the time the primary care nurse received training relevant to suicide policy. This policy did not identify registered nurses as staff responsible for completing suicide behavior reporting. It was rescinded and replaced by MCM 116-18-03, *Management of Veterans at High Risk for Suicide*, June 2018. The 2018 policy did identify registered nurses as responsible staff, however, was not in effect when the primary care nurse took the training.

[51] MCM 116-18-03, *Management of Veterans at High Risk for Suicide*, June 2018. This policy was in effect at the time the primary care provider received training relevant to suicide policy. It was rescinded and replaced by MCM 116-19-03, *Management of Veterans at High Risk for Suicide*, December 2019 and later replaced by MCM-116-21-03, *Management of Veterans at High Risk for Suicide*, January 2021, updated December 2021. The 2021 policy has the same language as the 2018 policy related to suicide prevention training and suicide behavior reporting responsibilities.

[52] MCM 116-18-03, *Management of Veterans at High Risk for Suicide,* June 2018. This policy was in effect for a portion of the time frame of the events discussed in this report. It was rescinded and replaced by MCM 116-19-03, *Management of Veterans at High Risk for Suicide*, December 2019 and later replaced by MCM-116-21-03, *Management of Veterans at High Risk for Suicide*, January 2021, updated December 2021. The 2021 policy has the same language as the 2018 policy related to suicide prevention training and suicide behavior reporting responsibilities.

- could not recall reading the primary care nurse's EHR note which contained the patient's reported cause of death;
- recalled reading the social work consult which did not contain the patient's cause of death;
- reported being unaware of the patient's cause of death when calling the family member upon receipt of the consult to discuss death benefits; and
- stated if the primary care nurse had disclosed the patient's death by suicide in the consult, the primary care social worker would have completed the SBOR and notified suicide prevention.[53]

During interviews facility leaders confirmed staff delayed completing the SBOR. The Facility Director informed the OIG that, in hindsight, the entry of the SBOR was delayed, and the Chief of Staff reported the expectation that at a minimum suicide prevention should have been notified when primary care staff first had knowledge of the patient's death by suicide. The ADPCS concurred the completion of the SBOR was delayed, however was unsure if nurses could complete an SBOR.

The OIG determined the primary care nurse and the primary care provider were aware of the patient's death by suicide as evident by documentation in the EHR, and failed to take actions to complete the SBOR, leading to a delay in timely documentation in accordance with facility and VHA policy.[54] The OIG found the primary care provider received training on the facility policy, which contained information on how to complete the SBOR; however, found no documented evidence that the primary care nurse received the required facility policy education.

Failure to Complete Behavioral Health Autopsy and Family Interview Tool Contact Form Within Required Time Frame

In December 2012, VHA implemented the BHA program, a quality improvement program that seeks to "identify contributory factors (e.g., psychosocial stressors, diagnoses, service utilization) relevant to [patient] suicides and VA suicide prevention efforts."[55] The BHA is completed through use of an EHR analysis template, which includes "demographic characteristics, risk &

[53] VA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide." The primary care nurse was a registered nurse, and the primary care social worker was a licensed clinical social worker. Both clinicians had the capability to complete the SBOR.

[54] VHA Directive 1160.07.

[55] VHA Deputy Under Secretary for Health for Operations and Management memorandum, "Behavioral Autopsy Program Implementation," December 11, 2012; VA, *Behavioral Health Autopsy Program Data Definitions: Description of Elements on the BHAP Chart Review and FIT-C form;* VA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide." The Behavioral Health Autopsy Program collects information from all veteran deaths by suicide reported to VA facilities to increase VA's knowledge of suicide on a national level using EHR review, family interviews, and reviews by Suicide Prevention coordinators.

protective factors, use of mental health and crisis services, diagnoses and symptoms, and clinical impressions."[56] VA policy also identifies that the facility suicide prevention coordinator must complete a FIT-C form, through a conversation with the deceased's family members explaining "the formal interview program and request their participation to understand the circumstances impacting the Veteran's life in the time before the death."[57] Per VHA, facility suicide prevention coordinators must conduct the BHA and complete the FIT-C form within 30 days of awareness of a patient's death by suicide.[58]

Through interviews and document review, the OIG learned that although suicide prevention staff became aware of the patient's death by suicide in late spring 2022, the BHA and FIT-C were not completed until early winter 2022, more than one month after the OIG opened the inspection. During an interview and through document reviews, the OIG learned that in spring 2022, the suicide prevention case manager completed the SBOR, but did not complete a BHA and FIT-C, which must be completed by a suicide prevention coordinator.[59] A suicide prevention coordinator, who completed the BHA and FIT-C, confirmed in an interview with the OIG, that the actions are either completed by a supervisor, or the task is delegated to a suicide prevention coordinator. The suicide prevention coordinator confirmed there was a delay in completing the BHA and FIT-C.

The OIG learned that in early winter 2022, a VISN leader asked the suicide prevention coordinator and the chief social worker for behavioral health to take action on the patient's missing BHA and FIT-C, more than seven months after the suicide prevention case manager completed the SBOR. The chief social worker for behavioral health recalled that in spring 2022, when suicide prevention staff first learned of the patient's death by suicide, a former suicide prevention program manager was responsible for tasking the suicide prevention staff with initiating the BHA and FIT-C, however, failed to take action. The chief social worker for behavioral health instructed the suicide prevention coordinator to complete the suicide postventions in early winter 2022. In an interview, the former suicide prevention program manager was unable to recall when the BHA and FIT-C were completed. The chief social worker for behavioral health reported the facility has a new process in place to ensure suicide after

[56] VA, Behavioral Health Autopsy Program Data Definitions: Description of Elements on the BHAP Chart Review and FIT-C forms.

[57] VA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide."

[58] VHA Directive, 1160.07; VA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide." After the BHA and FIT-C are completed, "statistical staff and program analysts . . .collect, process, and evaluate the information provided to uncover larger statistical trends and improve VA's [suicide prevention program]."

[59] VHA Directive, 1160.07; VA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide." Although a facility's suicide prevention team members may include suicide prevention coordinators, suicide prevention case managers, peer support specialists, and other designated staff; the completion of the BHA and FIT-C are the responsibility of the suicide prevention coordinator.

action requirements are completed "in a timely manner."

The OIG determined the suicide prevention coordinator did not timely complete the BHA and FIT-C as required by VHA, due to the former suicide prevention program manager's failure to task the actions to suicide prevention staff.[60]

Conclusion

The OIG substantiated that facility staff failed to approve and provide timely discharge medications for the patient. The OIG determined that clinical deficiencies in community care, primary care, and care provided by a VISN physician led to a delay in the patient's medications.

A community care nurse failed to communicate to facility providers, leading to gaps in care coordination. These gaps limited the information available to primary care staff and contributed to the delay and approval of the patient's medications. Further, primary care coordination and same-day access deficiencies contributed to the delay in ordering the patient's medications. A primary care nurse failed to respond timely to the patient's requests for assistance in obtaining medication by exceeding the call response time expectations set by VHA, which left the patient without clinical guidance and instruction on how to obtain the medication from the VHA pharmacy. Further contributing to the delay in medication, the patient was unable to access the Laughlin clinic due to a malfunctioning elevator and although facility leaders expressed their expectation that the primary care nurse would have seen the patient in the car, the patient's family reported the patient left without being seen by primary care staff. The OIG concluded the primary care provider did not provide same-day access to address the patient's needs and failed to coordinate the patient's care. Although the patient provided a discharge summary that was scanned and available in the EHR, the primary care provider's request to obtain another discharge summary from the community hospital further delayed the patient's discharge medications. Last, the OIG found the patient and family member did not receive education from VHA staff regarding how to obtain prescribed medication from the community hospital.

The OIG determined that a VISN physician lacked key information due to being unable to access scanned records in the patient's EHR, and failed to conduct a complete medication reconciliation, which contributed to an inadequate plan to address the patient's complex medical issues. The VISN physician failed to order the patient's anticoagulation medication due to lack of awareness of the process for ordering the medication. The OIG elevated patient safety concerns regarding providers' difficulties accessing scanned EHR records, and the VISN physician's lack of knowledge about ordering and expediting mailing of the anticoagulation medication. The VISN Quality Management Officer reported taking actions to educate the providers in VISN 21 in March and May 2023.

[60] VHA Directive, 1160.07.

The OIG determined primary care staff failed to notify suicide prevention staff upon learning the patient died by suicide and failed to complete an SBOR. Both the primary care nurse and primary care provider reported being unaware of the need to complete the SBOR, however, the OIG found evidence the primary care provider had received previous training. Additionally, the facility suicide prevention coordinator failed to timely complete a BHA and a FIT-C due to the former suicide prevention program manager's failure to task the actions to suicide prevention staff.

Recommendations 1–5

1. The North Las Vegas VA Medical Center Director reviews the community care coordination program, identifies deficiencies, and takes actions as warranted to ensure compliance with the Veterans Health Administration Field Guidebook, including training and completion of all care coordination responsibilities for patients discharged from a community hospital stay paid for by the VA.

2. The North Las Vegas VA Medical Center Director, in conjunction with the Primary Care Service chief, reviews the primary care processes, identifies deficiencies, and ensures compliance with Veterans Health Administration requirements, including response time to patients' scheduling requests and availability of same-day access for face-to-face and telephone encounters.

3. The Sierra Pacific Network Director in conjunction with the Chief Medical Officer continues the review of the complete course of care provided by the Veterans Integrated Service Network physician for the patient, including the delivery of anticoagulants, and ability to access scanned documents in the electronic health record, and takes actions as warranted.

4. The North Las Vegas VA Medical Center Director, in conjunction with the Behavioral Health Service chief and the Primary Care Service chief, review the suicide prevention training program to ensure compliance with Veterans Health Administration policies, including reporting requirements following a patient's death by suicide; identifies deficiencies; and takes actions as warranted.

5. The North Las Vegas VA Medical Center Director, in conjunction with the Behavioral Health Service chief, reviews the suicide prevention coordinators' compliance with Veterans Health Administration policies, including actions required to complete a behavioral health autopsy and family interview tool contact form following a patient's death by suicide; identifies deficiencies; and takes actions as warranted.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: December 13, 2023

From: Director, Sierra Pacific Network (10N21)

Subj: Healthcare Inspection—Care Concerns and Failure to Coordinate Community Care for a Patient at the VA Southern Nevada Healthcare System in Las Vegas

To: Office of the Under Secretary for Health (10)
Director, Office of Healthcare Inspections (54HL02)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. We deeply regret the circumstances that impacted the care delivered to one of our Veterans. I have reviewed the draft report Healthcare Inspection—Care Concerns and Failure to Coordinate Community Care for a Patient at the VA Southern Nevada Healthcare System in Las Vegas.

2. The VA Southern Nevada Healthcare System (VASNHS) is committed to honoring our Veterans by ensuring they receive high-quality healthcare services. I support the Director's response and the action plan of the VA Southern Nevada Healthcare System in Las Vegas.

3. I would like to thank the Office of Inspector General for their thorough review of this case and if you have any additional questions, please contact the VISN 21 Quality Management Officer (QMO).

(*Original signed by:*)

Ada Clark, FACHE, MPH
Network Director
VA Sierra Pacific Network (VISN 21)

VISN Director Response

Recommendation 3

The Sierra Pacific Network Director in conjunction with the Chief Medical Officer continues the review of the complete course of care provided by the Veterans Integrated Service Network physician for the patient, including the delivery of anticoagulants, and ability to access scanned documents in the electronic health record, and takes actions as warranted.

_X _Concur

____Nonconcur

Target date for completion: Complete.

Director Comments

The Sierra Pacific Network Director and the Chief Medical Officer reviewed the report and the concerns related to the Veterans Integrated Service Network physician and the course of care for the patient. In addition to the actions taken to ensure the provider was re-educated on the process for providing medications, re-educated on how to order prior authorization drug requests with urgency, as well as re-educated on the proper way to scan documents and access patient care and discharge information, the Chief Medical Officer conducted a detailed review of the complete course of care provided by the network physician. The detailed review included a clinical review of the delivery of anticoagulants, the documentation by the provider, medication orders, and the provider's clinical care decisions. Additionally, the chief medical officer ordered that the case be submitted for peer review. The physician's knowledge, skill, ability, and competence with accessing scanned documents in the electronic health record was verified. Moreover, the physician and the group of clinical resource hub physicians responsible for ordering direct oral anticoagulants were required to complete in-depth education on the process of ordering these medications, which require prior authorization. The Chief Medical Officer also added a licensed vocational nurse to the clinical team to increase the timeliness and efficiency of prior authorization reviews and the ordering process.

OIG Comments

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

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: January 9, 2024

From: Director, VA Southern Nevada Healthcare System (VASNHS-593)

Subj: Healthcare Inspection—Care Concerns and Failure to Coordinate Community Care for a Patient at the VA Southern Nevada Healthcare System in Las Vegas

To: Director, Sierra Pacific Network (10N21)

1. We are saddened by the loss of the patient and appreciate the opportunity to review the recommendations from OIG. Effective care coordination, among multiple providers across multiple settings has become even more critical due to the increased complexities within our health care environment. VASNHS remains committed to improving our processes to ensure each Veteran we serve receives the highest-quality healthcare services they deserve.
2. We agree with the OIG that it cannot be determined if the end result would have been different if the patient received the medications.
3. Please find the attached response to each recommendation included in the report. We have completed, or are in the process of completing, actions to resolve these issues. We will take actions as recommended by the OIG to strengthen the care we provide.

(*Original signed by*:)

William J. Caron, PT, MHA, FACHE
Medical Center Director/CEO
VA Southern Nevada Healthcare

Facility Director Response

Recommendation 1

The North Las Vegas VA Medical Center Director reviews the community care coordination program, identifies deficiencies, and takes actions as warranted to ensure compliance with the Veterans Health Administration Field Guidebook, including training and completion of all care coordination responsibilities for patients discharged from a community hospital stay paid for by the VA.

_X _Concur

____Nonconcur

Target date for completion: July 15, 2024

Director Comments

The North Las Vegas VA Medical Center Director, Associate Director of Patient Care Services/Nurse Executive (ADPCS/NE) and the Community Care Nurse Manager reviewed the deficiencies and opportunities identified in this report with care coordination for patients discharged from community hospitals. In collaboration with the ADPCS, the Community Care Nurse Manager developed a training plan and detailed competency checklists based upon requirements outlined in the Veterans Health Administration Field Guidebook regarding care coordination to ensure compliance with VHA requirements. By the end of FY 23, all applicable community care hospital staff had completed this training competency. Additionally, VASNHS Case Managers provided community hospital case managers a link to VHA's formulary to remind providers of the medications which are included on VA's medication formulary. Also, providers that participate in the Tri-West community care network receive required education on VA medication formulary guidelines. A monthly audit of a sample patients discharged from a community hospital stay paid for by the VA will be conducted by Community Care staff to ensure that completion of all care coordination responsibilities occur until 90% is achieved for three months. Audit results will be reported through VASNHS governance structure, Survey Readiness Committee until results achieved.

Recommendation 2

The North Las Vegas VA Medical Center Director, in conjunction with the Primary Care Service chief, reviews the primary care processes, identifies deficiencies, and ensures compliance with Veterans Health Administration requirements, including response time to patients' scheduling requests and availability of same-day access for face-to-face and telephone encounters.

_X __Concur

____Nonconcur

Target date for completion: July 15, 2024

Director Comments

The North Las Vegas VA Medical Center Director, Primary Care Service Chief and the Associate Nurse Executive, Ambulatory Care reviewed the deficiencies and opportunities identified in this report with primary care processes including response time to patients' scheduling requests and availability of same day access for face-to-face and telephone encounters. Previously, Patient Aligned Care Team (PACT) team nurses had individual voicemails and were responsible for timely follow-up (within one business day, or preferably within four hours), based upon the patient's clinical need. The telephone process changed in April 2023 so that patient phone calls to the clinics would now be routed to the VISN Clinical Contact Center to ensure a timely response. The Clinical Contact Center model was a national initiative to improve timely response to patients needs, including scheduling and same day access. The staff at the VISN Clinical Contact Center can also refer patients to the VISN Clinical Contact Center triage nurses, who can connect patients to the VISN Tele Emergency Care program with providers for immediate care and attention.

At the time of this event, there was one (1) full time provider at the Laughlin Clinic. Provider staffing has improved since this event; currently, there is one (1) full time provider, one (1) clinical resource hub provider, and two more providers are in the final stages of recruitment. Additionally, an assistant nurse manager was hired and two (2) more RN's [registered nurses] hired to assist with workload including transitions of care. Lastly, a rural navigator was hired to bolster our efforts in ensuring community care transitions occur smoothly and timely. A monthly audit will be conducted by primary care until 90% compliance is acheived for 3 months for patients who are assigned to a primary care provider and primary care nurse who request same day access for face-to face or telephone encounters and who receive same day access for face-to face or telephone encounters at the Laughlin Clinic. Audit results will be reported through VASNHS governance structure, Survey Readiness Committee until results are achieved.

Recommendation 4

The North Las Vegas VA Medical Center Director, in conjunction with the Behavioral Health Service chief and the Primary Care Service chief, review the suicide prevention training program to ensure compliance with Veterans Health Administration policies, including reporting requirements following a patient's death by suicide; identifies deficiencies; and takes actions as warranted.

_X __Concur

____Nonconcur

Target date for completion: June 1, 2024

Director Comments

The North Las Vegas VA Medical Center Director, Behavioral Health Service Chief and the Primary Care Service Chief reviewed the deficiencies and opportunities identified in this report including reporting requirements following a patient's death by suicide. The Suicide Prevention team will provide re-education to PACT direct patient care staff on the reporting requirements as outlined in the VHA Memorandum 2023-05-11, Update to Suicide Behavior and Overdose Reporting and VHA Directive 1160.07 Suicide Prevention Program, including notification to the Suicide Prevention Coordinator when there is a death by suicide and completion of the Suicide Behavior and Overdose Reporting (SBOR). A retrospective audit for timely completion of the SBOR by staff, when applicable over the last fiscal year (FY23) will be conducted by Behavioral Health leadership. Audit results will be reported through VASNHS governance structure, Behavioral Health Executive Committee. The Suicide Prevention team will also review any future events, which would require an SBOR, to ensure that it has been completed and that appropriate notifications have occurred.

Recommendation 5

The North Las Vegas VA Medical Center Director, in conjunction with the Behavioral Health Service chief, reviews the suicide prevention coordinators' compliance with Veterans Health Administration policies, including actions required to complete a behavioral health autopsy and family interview tool contact form following a patient's death by suicide; identifies deficiencies; and takes actions as warranted.

_X _Concur

____Nonconcur

Target date for completion: June 1, 2024

Director Comments

The North Las Vegas VA Medical Center Director, Behavioral Health Service Chief, Chief of Social Work Service, and Suicide Prevention Program Manager reviewed the deficiencies and opportunities identified in this report including actions required to complete the Behavioral Health Autopsy Program (BHAP) Chart Review and Family Interview Tool Contact (FIT-C) form following a patient's death by suicide. A retrospective audit of suicide reporting by the Suicide Prevention Team over the last fiscal year (FY23) will be conducted by Behavioral Health leadership for timely BHAP and FIT-C. Appropriate re-education by Behavioral Health leadership will occur for any deficiencies identified. Audit results will be reported through VASNHS governance structure, Behavioral Health Executive Committee. Behavioral Health

Leadership will also review any future events, which would require a BHAP Chart Review and FIT-C form to ensure that these have been completed.

Glossary

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

allopurinol. A medication used to lower high or excess uric acid levels, which can cause gout.[1]

anticoagulant. A medication used to stop blood from clotting.[2]

apixaban. An oral medication that is used to prevent blood clots in patients, by decreasing the clotting ability of the blood.[3]

atorvastatin. A medication used in conjunction with a good diet to lower cholesterol and may help prevent medical problems including stroke.[4]

atrial fibrillation. A condition that occurs when the upper and lower chambers of the heart are not synced, which may cause rapid heartbeat, chest pain and difficulty breathing.[5]

azithromycin. A medication "used to treat certain bacterial infections in many different parts of the body."[6]

carvedilol. A medication used to treat elevated blood pressure and can also be used as a treatment for heart related conditions such as congestive heart failure.[7]

chronic kidney disease. Also known as chronic kidney failure, is the gradual loss of kidney function with decreased ability of the kidneys to filter waste and remove excess fluids from the blood through the urine.[8]

[1] Mayo Clinic, "allopurinol (oral route)," accessed April 25, 2023, https://www.mayoclinic.org/drugs-supplements/allopurinol-oral-route/description/drg-20075476.

[2] Cleveland Clinic, "Anticoagulants," accessed October 16, 2023, https://my.clevelandclinic.org/health/treatments/22288-anticoagulants.

[3] Mayo Clinic, "apixaban (oral route)," accessed November 21, 2022, https://www.mayoclinic.org/drugs-supplements/apixaban-oral-route/description/drg-20060729?p=1.

[4] Mayo Clinic, "atorvastatin (oral route)," accessed April 25, 2023, https://www.mayoclinic.org/drugs-supplements/atorvastatin-oral-route/description/drg-20067003.

[5] Mayo Clinic, "atrial fibrillation," accessed April 25, 2023, https://www.mayoclinic.org/diseases-conditions/atrial-fibrillation/symptoms-causes/syc-20350624.

[6] Mayo Clinic, "azithromycin (oral route)," accessed April 25, 2023, https://www.mayoclinic.org/drugs-supplements/azithromycin-oral-route/description/drg-20072362.

[7] Mayo clinic, "carvedilol (oral route)," accessed April 25, 2023. https://www.mayoclinic.org/drugs-supplements/carvedilol-oral-route/description/drg-20067565.

[8] Mayo Clinic, "chronic kidney disease," accessed May 14, 2020, https://www.mayoclinic.org/diseases-conditions/chronic-kidney-disease/symptoms-causes/syc-20354521.

diuretic. Commonly used in the treatment of elevated blood pressure by boosting the kidney's ability to increase the amount of sodium into urine and reducing the amount of fluid in the bloodstream.[9]

electrocardiogram. A medical test records the electrical signals occurring in the heart and is used by a health care provider to assess for a wide variety of heart related symptoms.[10]

Entresto. The brand name for the combination of two medications (sacubitril and valsartan), prescribed to manage symptoms associated with heart failure.[11]

external defibrillator vest. A wearable vest worn directly against the skin to detect certain rapid heart rhythms to automatically deliver a treatment shock to save a patient's life.[12]

furosemide. A medicine that belongs to a group of diuretic medications, which helps treat fluid retention caused by certain medical conditions including congestive heart failure.[13]

gastroesophageal reflux disease. The chronic irritation of the tissue lining the esophagus, caused by repetitive exposure to excess stomach acid.[14]

gout. A painful condition in which at least one joint in the body becomes inflamed with undisposed uric acid crystals.[15]

heart failure. Also known as congestive heart failure, it is the reduced ability for the heart to circulate blood in the body, which can cause fluid to accumulate in the lungs, causing pain and restricting breathing.[16]

[9] Mayo clinic, "diuretics," accessed April 25, 2023, https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/in-depth/diuretics/art-20048129.

[10] Mayo Clinic, "electrocardiogram (ECG or EKG)" accessed April 25, 2023, https://www.mayoclinic.org/tests-procedures/ekg/about/pac-20384983.

[11] Mayo Clinic, "sacubitril and valsartan (oral route)," accessed November 21, 2022, https://www.mayoclinic.org/drugs-supplements/sacubitril-and-valsartan-oral-route/description/drg-20150920.

[12] ZOLL LifeVest, "wearable cardioverter defibrillator" vest, accessed November 21, 2022, https://lifevest.zoll.com/.

[13] Mayo Clinic, "furosemide (oral route)," accessed April 25, 2023, https://www.mayoclinic.org/drugs-supplements/furosemide-oral-route/description/drg-20071281.

[14] Mayo Clinic, "gastroesophageal reflux disease (GERD)," accessed April 25, 2023, https://www.mayoclinic.org/diseases-conditions/gerd/symptoms-causes/syc-20361940.

[15] Mayo Clinic, "gout," accessed April 25, 2023, https://www.mayoclinic.org/diseases-conditions/gout/symptoms-causes/syc-20372897.

[16] Mayo Clinic, "heart failure," accessed April 24, 2023, https://www.mayoclinic.org/diseases-conditions/heart-failure/symptoms-causes/syc-20373142.

losartan. A medication used to treat high blood pressure, either alone or with other medications, to relax blood vessels to lower blood pressure and may reduce the risk of heart attacks or strokes.[17]

metformin. A medication used to treat high blood sugar levels in persons with diabetes, where insulin is not able to get sugar into the body's cells. The medication helps restore the way a person uses food to make energy.[18]

pneumonia. A condition which occurs within the lung(s) and occurs with an infection of the air sacs causing respiratory symptoms such as shortness of breath, and for patients older than 65, it can be a more serious condition.[19]

prior authorization drug request. The process in which certain medications are reviewed prior to prescribing, to ensure the medication is safe and appropriate for use. Prior authorization reviews are completed at the national, VISN, or facility level, depending on the medication designation.[20]

[17] Mayo Clinic, "losartan (oral route)," accessed April 25, 2023, https://www.mayoclinic.org/drugs-supplements/losartan-oral-route/description/drg-20067341.

[18] Mayo Clinic, "metformin (oral route)," accessed April 25, 2023, https://www.mayoclinic.org/drugs-supplements/metformin-oral-route/description/drg-20067074.

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[20] VHA Directive 1108.08(1), *VHA Formulary Management Process,* November 2, 2016, amended August 29, 2019. It was rescinded and replaced by VHA Directive 1108.08, *VHA Formulary Management Process*, July 29, 2022.

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