



# DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

## COMPANION PODCAST TRANSCRIPT

Failures in Care Coordination and Reviewing a Patient's Death at the  
VA Salt Lake City Health Care System, Utah  
August 2021

### Introduction

Hello listeners! Thank you for listening to this companion podcast produced by the Department of Veterans Affairs Office of Inspector General. Companion podcasts summarize and increase awareness of VA OIG published reports and regularly feature those OIG employees who conducted the report, inspection, or investigation. Find all VA OIG podcasts online at [va.gov/oig](http://va.gov/oig).

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Lisa Barnes:

This is Lisa Barnes, associate director with the Office of Healthcare Inspection. I'm here with healthcare inspectors Eileen Keenan and Sonia Whig and we are going to discuss the report, [\*Failures in Care Coordination and Reviewing a Patient's Death at the VA Salt Lake City Health Care System in Utah\*](#), that was published in July 2021. This report looked at care coordination, hiring of a pharmacist, and relocation of a community-based outpatient clinic. Eileen, how did the OIG first become involved with the issues?

Eileen Keenan:

Thank you, Lisa. Like with many of our healthcare inspections, the OIG received the three allegations through its hotline division. The first allegation involved a lack of care coordination that caused a delay in the patient getting anticoagulation medication, also known as a blood thinner, filled by the VA. The second allegation asserted that the refusal of the chief of pharmacy to hire a pharmacist at the Idaho Falls community-based outpatient clinic contributed to the patient's death. The third allegation claimed that a delay occurred with the relocation of a community-based outpatient clinic in Orem, Utah, to a new site. And because of that delay, the facility director put patients and staff at risk of contracting COVID-19 because of an order to bus patients from the Orem clinic to the main campus in Salt Lake City for blood work and appointments.

Lisa Barnes:

So, this hotline inspection looked into several different and somewhat unrelated allegations. Can you take us through the first allegation?

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Eileen Keenan:

Certainly, the first allegation stated that a lack of care coordination caused a delay in care when a patient, recently discharged from a non-VA community hospital, was unable to get the anticoagulation medication filled and covered by the VA. The patient was admitted to a non-VA community hospital on a Tuesday and was discharged late Friday afternoon. The patient was started on anticoagulation medication to treat a saddle pulmonary embolism and was given a prescription at discharge for a one-month supply of medication and advised to follow up with the VA. The patient did not get the prescription filled at a local pharmacy due to cost and decided to wait until the following Monday morning to contact the VA for assistance with getting the prescription filled.

It's important to note that VA patients' electronic health records are not connected to non-VA health records. However, when the VA receives non-VA health records, that information is scanned into the patients' VA electronic health records.

The OIG found that at the time of discharge the non-VA community hospital provided the patient with a discharge summary, a prescription and savings card for a one-month supply of the anticoagulation medication, education on the importance of the medication, and a follow-up call the day after discharge. In addition, on Friday afternoon, the non-VA community hospital faxed a copy of the discharge summary and the prescription to the Idaho Falls clinic. Unfortunately, the fax was sent after the clinic closed for the day and weekend.

Lisa Barnes:

You mentioned anticoagulation medications are blood thinners. Could you tell us about the importance of this medication and what it may mean if a patient misses a dose or two?

Eileen Keenan:

Of course. Anticoagulation medications are used to prevent blood clots from forming. They can also keep existing blood clots from getting larger. If a blood clot occurs, it can travel to the lungs causing a pulmonary embolism, which is a blockage of blood flow to one or both pulmonary arteries in the lungs. Blood clots can be life threatening and if anticoagulation medication is suddenly stopped, a person is at a higher risk of having a stroke.

Lisa Barnes:

It sounds like the non-VA community hospital did what they were supposed to do. So, did something else cause a delay?

Eileen Keenan:

Yes. On Monday, the patient called the Idaho Falls clinic requesting assistance in getting the medication prescription filled and stated being off the medication since Friday. The clerk who took this call was

unable to reach the patient's nurse care manager and asked another nurse care manager that was at the clinic for assistance. The other nurse care manager was able to reach the patient's nurse care manager, relayed the patient's request, and discussed the urgency of the patient being off of the medication since Friday.

The patient's nurse care manager documented the patient's urgent condition and entered a consult to the anticoagulation pharmacist, who unfortunately was on leave that day. From interviews and the electronic health record, we learned that no other follow-up actions were done to assist the veteran in getting this medication. The patient died on Tuesday, after being off the blood thinning medication for four days. The cause of death is unknown because an autopsy was not performed. The OIG asserts that if the patient's nurse care manager had pursued other actions on Monday, the patient may have gotten the necessary medications or been advised to return to the nearest emergency department for evaluation and treatment.

Lisa Barnes:

This seems like a coordination failure. It's concerning as so many veterans get care outside of the VA but rely on coordinating follow-up with their VA providers. What did the facility leaders do to understand the failures in caring for this veteran?

Eileen Keenan:

The facility conducted an internal review to discover the root cause of the event. However, the internal review focused on systems and processes, not on the missed opportunities of the clinical staff to meet the patient's urgent need. Understanding why the nurse care managers didn't respond more urgently or follow up with the patient is critical to making sure nothing like this happens again. In regard to whether the nurses understood the clinical significance of this patient being without the blood thinner—perhaps training and education of staff is appropriate. Determining all the barriers that were present that prevented this patient from getting the care needed is a critical step and ultimately the responsibility of the facility leaders. Another consideration would be whether an institutional disclosure was warranted, which is a formal process by which VA leaders and other staff as well as the patient's providers inform the patient or the patient's personal representative that an adverse event occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury. In addition, VA provides specific information about the patient's rights and recourse.

Lisa Barnes:

Thank you, Eileen. Sonia, what can you tell us about the other two allegations?

Sonia Whig:

Thanks Lisa. The second allegation stated that the chief of pharmacy refused to hire pharmacists at the Idaho Falls community-based outpatient clinic, and that had there been a pharmacist at the clinic, the patient would have been able to fill his prescription. Although budgetary constraint resulted in a hiring freeze at the facility, off-site clinical pharmacists and a technician were available to Idaho Falls clinic staff and patients through virtual consults and by telephone, email, and instant messaging. In interviews, the OIG team was told that not all clinic needed to have a pharmacist on-site, and that no request for clinical pharmacists had been denied.

Lisa Barnes:

So, in reference to the patient we discussed, did lack of access to an on-site pharmacist matter?

Sonia Whig:

Unfortunately, the non-VA hospital faxed a copy of the patient's prescription to the Idaho Falls clinic on a Friday afternoon at 4:46 p.m., which is after the clinic closed for the day and weekend. Staff did not receive the prescription until Monday morning. Having a full- or part-time pharmacist located at the clinic would not have affected this particular patient as the fax was sent after the clinic closed.

Lisa Barnes:

That makes sense. Now to the third allegation, which involved the relocation of the community-based outpatient clinic in Orem, Utah, and transporting of patients. Can you elaborate on it?

Sonia Whig:

Sure. The third allegation stated that there were delays in opening the relocated Orem clinic, and because of this, the facility director ordered patients to be bussed from Orem to the main campus in Salt Lake City for blood work and appointments, which exposed patients and staff to increased risk of contracting COVID-19.

Lisa Barnes:

There is a lot to that allegation. Let's start with the delay in relocation. What happened there?

Sonia Whig:

Due to increased demand and the need for more space, the clinic in Orem was being relocated. The facility's lease committee ensured that the design for the new clinic was completed, secured the building permit, and set an opening date for September 2020, as the lease for the old clinic expired on September 30. Because of COVID-19, construction and manufacturing delays occurred. The facility extended the lease agreement for the old clinic site by 30 days and developed a contingency plan to use a Mobile Vet

Center unit to provide limited patient care to ensure continuity of care. The new clinic in Orem opened on December 1, 2020.

Lisa Barnes:

So, in realizing there would be a delay in the relocation, the facility took the necessary steps to ensure patient care. How does this relate to the allegation that the facility director ordered patients to be bussed to Salt Lake City?

Sonia Whig:

The facility does not offer routine van service between the Orem clinic and the main campus in Salt Lake City. If a patient needed care at the main campus and was unable to drive, the patient calls the facility's transportation department to arrange for van service to and from the main campus. Between March and December 2020, six patients were transported from the Orem clinic to the main campus. The facility director did not order the bussing of patients.

The last part of the third allegation is about the risk of exposure to COVID-19 by patients and staff during transport. The facility developed procedures on transporting patients and cleaning processes post-transportation. Personal protective equipment was required to be worn by patients and staff. None of the six patients that used the van service nor the van drivers themselves tested positive for COVID-19.

Lisa Barnes:

Well that's good news. What were the final recommendations to the facility?

Sonia Whig:

Ultimately, the OIG recommended that the facility director conduct a clinical care review of the patient who died, review the root cause analysis processes, and determine the need for an institutional disclosure.

Lisa Barnes:

Eileen and Sonia, thank you for your time today. I encourage those listening to visit the VA OIG's website and read the full report. There you will also find all of OIG's published reports, including the recently published Semiannual Report to Congress, which covers the VA OIG's work over the past six months.

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